DEPARTMENT OF HEALT	MEDICA	ARE/MEDICAI			ND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: KKYX
1. MEDICARE/MEDICAID PROVIDE		3. NAME AND AL	DDRESS OF FAC	CILITY	E SURVEY AGENCY	Facility ID: 00872 4. TYPE OF ACTION: 7 (L8)
(L1) 245293 2.STATE VENDOR OR MEDICAID N	NO.	(L3) GOLDEN L (L4) 725 SECON			IINS	1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 417633200		(L5) HOPKINS, I			(L6) 55343	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF ((L9) 11/01/2002	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
)3/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a): To (b):		Compliance	equirements e Based On:		And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	138 (L18)	l. A	cceptable POC		4. 7-Day RN (Rural SN <u>5</u> . Life Safety Code	F) 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	138 (L17)	B. Not in Comp Requirements	liance with Progra and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 18/19 SNF 138	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gloria Derfus, Unit	t Supervisor	0	01/31/2017	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 3/6/2017 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	IATE AGENCY
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 			IPLIANCE WITH ITS ACT:	H CIVIL	 Statement of Finan Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/01/1985	BEGINNINC	DATE	ENDING DA	ТЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	8
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	<i>(</i> , , , ,)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	00040		(L31)		
31. RO RECEIPT OF CMS-1539		. DETERMINATION				
	(L32)			(L33)	DETERMINATION APPR	201/01
	()			(200)	PETERMINATION AFFF	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245293

January 31, 2017

Ms. Talia Aramalay, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, MN 55343

Dear Ms. Aramalay:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 13, 2016 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 23, 2017

Ms. Talia Aramalay, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, MN 55343

RE: Project Number S5293027

Dear Ms. Aramalay:

On November 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016 that included an investigation of complaint numbers H5293055 and H5293058. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 13, 2016 and therefore remedies outlined in our letter to you dated November 30, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVIS	SIT
	B. Wing	Y2	1/3/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - HO	PKINS	725 SECOND AVENUE SOUTH		
		HOPKINS, MN 55343		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0157	Correction	ID Prefix	F0174		Correction	ID Prefix	F0241		Correction
Reg. #	483.10(b)(11)	Completed	Reg. #	483.10	(k),(l)	Completed	Reg. #	483.15(a)		Completed
LSC		12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0246	Correction	ID Prefix	F0278		Correction	ID Prefix	F0282		Correction
Reg. #	483.15(e)(1)	Completed	Reg. #	483.20	(g) - (j)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC		12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0309	Correction	ID Prefix	F0311		Correction	ID Prefix	F0312		Correction
Reg. #	483.25	Completed	Reg. #	483.25	(a)(2)	Completed	Reg. #	483.25(a)(3)		Completed
LSC		12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0371	Correction	ID Prefix	F0431		Correction	ID Prefix	F0458		Correction
Reg. #	483.35(i)	Completed	Reg. #	483.60	(b), (d), (e)	Completed	Reg. #	483.70(d)(1)(ii)		Completed
LSC		12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.70(h)	Completed	Reg. #			Completed	Reg. #			Completed
LSC		12/13/2016	LSC			_	LSC			
REVIEWE STATE AC		REVIEWED BY (INITIALS) GD/kfd	DATE 1/23/201	17	SIGNATURE OF	SURVEYOR	18623		DATE 1/3/2	2017
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW		Y COMPLETED ON		CK FOI ORREC	RANY UNCORRE	CTED DEFICIEN IES (CMS-2567)	ICIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?		s 🗌 no

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF RE	VISIT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245293 _{Y1}	B. Wing	Y2	1/6/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - HO	DPKINS	725 SECOND AVENUE SOUTH		
		HOPKINS, MN 55343		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
	10	17	10		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
NFPA 101 Reg. #	Completed	Reg. #	A 101 Completed	Reg. #	Completed
LSC K0352	12/13/2016	LSC K071	2 12/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC				LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TL/kfd	DATE 1/23/2017	SIGNATURE OF SURVEYOR	37009	DATE 1/6/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 11/1/2016	Y COMPLETED ON		DR ANY UNCORRECTED DEFICIE ECTED DEFICIENCIES (CMS-2567		

DEPARTMENT OF HEALT	FH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: KKYX
	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00872
1. MEDICARE/MEDICAID PROVII (L1) 245293	DER NO.	3. NAME AND AI (L3) GOLDEN L			KINS	4. TYPE OF ACTION: <u>2</u> (L8)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 725 SECON	D AVENUE SC	OUTH		1. Initial2. Recertification3. Termination4. CHOW
(L2) 417633200		(L5) HOPKINS,	MN		(L6) 55343	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	
(L9) 11/01/2002		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 11/	03/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EISCAL VEAD ENDING DATE: (125)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		•			3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	138 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF)8. Patient Room Size
13.Total Certified Beds	138 (L17)	X B. Not in Con	npliance with Prog	ram	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied W	Vaivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	5 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
138						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	YAPPROVAL Date:
Magdalene Jares	<u>, HFE NE II</u>	1	2/13/2016	(L19)	Kamala Fiske-Downing	, Enforcement Specialist 01/06/2017 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBI	ILITY		IPLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
 Facility is Eligible to 	Participate	RIGH	HTS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligib	-				5. Both of the Hoove	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY
10/01/1985					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on OTHER
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B Rescind St	spension Date:	(L44)			00-Active
	D. Reseniu St	ispension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS	
		00040				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	20	. DETERMINATION		DATE		
51. KO KECEIF I OF UMO-1559		. DETERIVIIINATION	OF AFFKUVAL	Ļ		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 30, 2016

Ms. Talia Aramalay, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, MN 55343

RE: Project Number S5293027

Dear Ms. Aramalay:

On November 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5293055 and H5293058.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 13, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 13, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Golden LivingCenter - Hopkins November 30, 2016 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

Golden LivingCenter - Hopkins November 30, 2016 Page 5

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Golden LivingCenter - Hopkins November 30, 2016 Page 6

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

		& MEDICAID SERVICES					APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION			E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG			IPLETED
							С
		245293	B. WING _			11/	03/2016
NAME OF F	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	DPKINS		725 SECOND AV HOPKINS, MN			
				-			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0(00			
	as your allegation o Department's accept	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance.					
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with					
	through 11/3/16, co	ation survey on 10/31/16, mplaint investigation(s) were he time of the standard					
	completed. The cor	complaint, H5293055 was nplaint was substantiated. ed at F157 and F174.					
F 157 SS=D	completed. The cor		F 1	57			12/13/16
	consult with the res known, notify the re or an interested fan accident involving tl injury and has the p intervention; a signi physical, mental, or deterioration in hea	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ficant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial hreatening conditions or					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/09/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES			RINTED: 01/04/20 FORM APPROVI MB NO. 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		245293	B. WING		11/03/2016
NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC
F 157	significantly (i.e., a existing form of treat consequences, or the treatment); or a dece the resident from the §483.12(a). The facility must also and, if known, the r or interested family change in room or specified in §483.1 resident rights under regulations as spect this section. The facility must re the address and philegal representative this REQUIREMENT by: Based on interview facility failed to ensist representative was changed and change resident (R191) revision Findings include: R191's diagnoses i without behavioral of acute kidney failure from the Admission	has); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of cord and periodically update ione number of the resident's e or interested family member. NT is not met as evidenced w and document review, the	F 15	7 Submission of this Response and I correction is not a legal admission t deficiency exists or that this Statem Deficiency was correctly cited, and not to be construed as an admissio fault by the facility, the Executive Di or any employees, agents or other individuals who draft or may be disc in the Response and Plan of Correc In addition, preparation and submis this Plan of Correction does not cor an admission or agreement of any I the facility of the truth of any facts a or the correctness of any conclusion forth in the allegations.	hat a ent of is also n of rector cussed ction. sion of nstitute kind by illeged

Facility ID: 00872

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245293	B. WING	i			C 03/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HC	PKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	edema (swelling) or redness on the righ been started on a n milligram (mg) by m days for edema. During review of the progress notes date was revealed the m documentation the had been notified of R191's care plan da resident had a diag dementia, due to co decision making ca resident resided in t Unit (ACU). R191's cognitive los Assessment (CAA) resident had demer family. On 11/3/16, at 7:28 (LPN)-C verified res Lasix on 1/26/16, ho lacked documentati representative had treatment changes On 11/3/16, at 7:35 services (DNS) stat the staff nurse to do been notified of any included the medica	it was revealed resident had n both lower extremities, some t inner thigh and resident had ew order for Lasix 20 nouth every morning for three e interdisciplinary team (IDT) ed 1/7/16, through 1/29/16, it edical record lacked wife or legal representative f the change in condition and	F	157	Accordingly, the Facility has prepar submitted this Plan of Correction pre- the resolution of any appeal which in filed solely because of the requirem under state and federal law that ma- submission of a Plan of Correction ten (10) days of the survey as a cor- to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. The resident, R191, no longer res- the facility. For all residents residing in the fa- the legal representative or an intere- family member will be notified of an changes in resident condition or treatments. The licensed nurses, the social w and the registered dietician have be re-educated on the requirement to the representative or interested family member when they occur. Monitoring to ensure compliance conducted through random documentation audits to ensure that proper notification has taken place been documented for changes in re conditions and treatments. The facility QAPI committee will re the documentation audits quarterly further recommendations. The date of completion will be 12	rior to may be lents undate within ndition s sides at cility ested y orkers een notify es in ne legal will be t and esident eview for	

Facility ID: 00872

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATI COM	E SURVEY IPLETED
		245293	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	N LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	legal representative change in condition On 11/3/16, at 7:50 conversation a fam not pleased with the R191 was in the fac during one visit to the were swollen like a Lasix. I was never in changes." Family in R191's legal represe be told. The facility Notificat Health Status policy "The center will cor- nurse practitioner of known notify the rea an interested family (A) An accident whi potential for requirin Notification: Within assessment has be be a potential for pl (B) Acute illness or resident's physical, (i.e. deterioration in status in either life- clinical complication (C) A need to alter in need to discontinue due to adverse con- new form of treatments.	 a had been notified of the n and treatment plan. a.m. via a telephone illy member stated they were e care during the brief time cility. Family member indicated the facility had noticed "his feet balloon. I think he needed notified of any medication nember indicated she was sentative and was supposed to tion of Change in Resident y dated 10/12/16, directed noult the resident's physician, or physician assistant, and if sident's legal representative or y member when there is: ich results in injury and has the ng physician intervention. 24 hours from the time as een made indicating there may hysician intervention. a significant change in the mental, or psychosocial status in health, mental, psychosocial threatening conditions or ns.) treatment significantly (i.e. a e an existing form of treatment as equences, or to commence a 	F 15			

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TATEN.	RS FOR MEDICARE				OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
						С
		245293	B. WING _			03/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 157	2007, provided to re	ts Bill of Rights dated July 1,	F 15	57		
F 174 SS=D	Your Condition. The immediately when t	a facility must consult with you here is an accident involving. ΓΤΟ TELEPHONE ACCESS	F 17	74		12/13/16
		e right to have reasonable of a telephone where calls can				
	personal possessio furnishings, and ap permits, unless to c	e right to retain and use				
	This REQUIREMEN	NT is not met as evidenced				
	Based on interview facility failed to disc personal property for addition failed to inv missing personal cl R191 when family o	and document review, the charge resident with all or 1 of 3 residents (R191). In vestigate and follow up on othing for the same resident contacted the facility.		The resident, R191, no longer the facility. For all residents admitted to personal property inventory for completed. The personal prope inventory form will be given to the resident, or resident's legal rep	the facility a m will be erty he resentative	
	Findings include:	ncluded unspecified dementia		or interested family member to copy of the form will be placed medical record. Upon discharg	sign and a in the	
	without behavioral of acute kidney failure	disturbance, hypothyroidism, and repeated falls obtained Record dated 4/26/16.		facility the personal inventory for reviewed with resident, or resident representative or interested far member to sign and ensure all	orm will be lent's legal nily	
		the medical record dated 9/16, it was revealed on		belongings are accounted for. the signed personal inventory f	A copy of	

Facility ID: 00872

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		& MEDICAID SERVICES	(X2) MHTTI	PLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
					(C
		245293	B. WING		11/0	03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOLDEN	I LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 174	Continued From pa	-	F 17		in a lange and the second	
	1/29/16, the record had been sent with property/belongings On 11/3/16, at 7:42	a.m. when asked if she had		then be placed in the med discrepancies with person be investigated and resolu- will be documented. Licensed social workers re-educated on the require	al property will ition of problem have been ement to have	
	missing clothing, th director stated she had indicated she v clothing that was no	to R191's family regarding the e Alzheimer's Care Unit (ACU) had left voice messages and vould bring back the other ot R191's. ACU director stated ne wife she would be looking		the personal inventory for completed, reviewed and admission and discharge. social workers have also b re-educated on the require investigate any discrepand	signed upon The licensed been ement to	
	for the clothing and the clothing she had clothes then bring a be able to reimburs had not heard from messages. ACU din had brought back th	if she was not able to locate d asked the wife to go buy the a receipt and the facility would e her. ACU director stated she the wife since the voice rector further stated the wife ne clothing that did not belong		document resolutions of d with personal belongings i record. Monitoring to ensure con conducted through randor for residents admitting and from the facility.	iscrepancies n the medical mpliance will be n chart audits d discharging	
	medical record lack telephone conversa staff to R191's wife property issue and investigating the los facility policy was o supposed to docum sent with resident/fa	ever, ACU director verified the ted documentation of the ations and calls from the facility regarding the personal if the facility was looking or as. When asked what the n discharge if the staff was nent belongs/personal property amily ACU director stated she		The facility QAPI commi the personal inventory cha quarterly for further recom The date of completion v	art audits mendations.	
	conversation a fam pleased with the ca was in the facility. F time of discharge th family in transferrin the family had to do Family member sta	a.m. via a telephone ily member stated she was not re during the brief time R191 Family member indicated at the ne facility staff did not assist g resident into the vehicle and b it all which was difficult. ted the clothing sent with ong to R191. Family member				

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 174	indicated she had n to the facility regarc property pieces how call back if the facili items. Family mem back all the clothing belong to R191. Fa purchased resident the missing ones th she had identified th admitted to another facility staff had call receipt for the faciliti items wife stated no voice message. Wh her to bring the recor recently passed aw of grieving thanked glad someone is loo On 11/3/16, at 8:16 the facility policy wit policy indicated a for R191's care plan da resident had a diag dementia, due to co decision making ca resident resided in Unit (ACU). R191's cognitive los Assessment (CAA) resident had demer family. Your Rights Under	nade several telephone calls ding the missing personal wever, had never received any ity was looking for the missing ber indicated she had brought g sent with resident that did not amily member stated she had clothing and shoes to replace the facility had misplaced after he issue after R191 was r facility. When asked if the led and informed her to bring a ty to reimburse the missing obody had called or left any nen asked if it was possible for eipt wife stated R191's had ray and she was in the process for looking into the issue "am oking into this." a.m. ACU director reviewed th surveyor and verified the orm was to be filled. ated 1/11/16, indicated nosis of Alzheimer's or related ognitive loss, had diminished pabilities and as a result the secured Alzheimer's Care ss/dementia Care Area dated 1/20/16, indicated ntia and had a supportive The Combined Federal and ts Bill of Rights dated July 1,	F	174			

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						FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL 245293 B. WIN NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HOPKINS (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRE PRE TA F 174 Continued From page 7 representative directed "34. You have the right to retain and use personal possessions including some furnishings and appropriate clothing as space permits, unless it would infringe upon other resident's rights, health and safety. The facility must either maintain a central locked depository or provide individual locked storage areas in which you may store your valuables for safekeeping. The facility is responsible for reasonable preventive measures such as counseling you and your family members about the reasonable risks of brining valuable personal items into the facility, the desirability of labeling your belongings, have doors on all closets, and investigating incidents of loss or damage. The facility may, but is not required to, provided to, provide compensation for lost or stolen items" The facility Discharge/Transfer of the Resident reviewed 8/29/16, directed staff: "7. Check belongings. a. Give copy to resident and/or representative. b. Place original in the medical record. 8. Escort resident in wheelchair out of facility unless transported via ambulance. Assist with belongings as necessary"			ING .			IPLETED C
		245293	B. WING				03/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	representative direct retain and use pers some furnishings at space permits, unlet resident's rights, he must either maintai or provide individua which you may stor safekeeping. The fa reasonable prevent counseling you and the reasonable risks items into the facilit your belongings, ha investigating incident facility may, but is m provide compensati The facility Dischard reviewed 8/29/16, d "7. Check belonging resident and/or repi giver sign for belong a. Give copy to representative. b. Place origina 8. Escort resident in unless transported belongings as nece 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each resident reside	cted "34. You have the right to onal possessions including appropriate clothing as ass it would infringe upon other path and safety. The facility in a central locked depository all locked storage areas in e your valuables for acility is responsible for ive measures such as your family members about is of brining valuable personal y, the desirability of labeling we doors on all closets, and ints of loss or damage. The not required to, provided to, ion for lost or stolen items" ge/Transfer of the Resident lirected staff: gs and inventory form-Have resentative or responsible care gings. resident and/or all in the medical record. In wheelchair out of facility via ambulance. Assist with asary" AND RESPECT OF	F 1				12/13/16

Facility ID: 00872

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION	1	0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		045000				С
		245293	B. WING _			03/2016
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STATE, ZIP CO 725 SECOND AVENUE SOUTH	DE	
				HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	ge 8	F 24	41		
		NT is not met as evidenced				
	for 1 of 3 residents incontinence. Findings include: During a random of a.m. the door of the the nursing station assistant (NA)-A re- licensed practical n able to see R44 sea abdomen, left hip a standing outside the blue shirt pulled up were covering R44' of the toilet. During observation was brought to the the nurses' station. was no curtain arou room. At 9:51 a.m. shower room. Survey was able to see R4 a.m. NA-A then ent	ailed to provide visual privacy (R44) reviewed for urinary oservation on 11/3/16, at 7:13 e shower/tub room across from was noted open. Nursing quested something from urse (LPN)-D. Surveyor was ated on the toilet. R44's bare nd left thigh were visible when e hallway. R44 was wearing a and dark blue sweat pants is feet lying on the floor in front on 11/3/16, at 9:45 a.m. R44 shower/tub room across from NA-A and NA-C verified there und the toilet in the shower/tub NA-A and NA-c exited the eyor sitting at the nursing desk 4 sitting on the toilet. At 9:57 ered the shower room and to see R44 sitting on the toilet		be maintained for all toileting The privacy curtain will be in pulled to ensure visual privacy The visual privacy for all re- be maintained for all toileting cares by ensuring that privac in place and utilized. All nursing staff and therapi been re-educated on the require ensure visual privacy will be n for all residents when providin assistance with toileting and cares by utilizing privacy curts All housekeeping staff have re-educated on the requirement promptly replace privacy curts removal for cleaning. Monitoring to ensure complic conducted through random of care audits to ensure the use curtains during personal care environmental audits be cond ensure privacy curtains are in required areas. The facility QAPI committee the observational care audits environmental audits quarter	place and y. sidents will and personal y curtains are sts have uirement to maintained ng personal ains. been ent to ains upon iiance will be bservational of privacy s. Weekly ducted to n place in e will review and	
	10/12/16, indicated impaired with verba others one to three period. R44's MDS assistance of two s	in exposed. imum Data Set (MDS) dated R44 was severely cognitively al behaviors that affected days during the observational indicated R44 required taff to use the toilet, and was ent of bladder and always		recommendations. The date of completion will	be 12-13-16.	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0,2010
	N LIVINGCENTER - HO			7	725 SECOND AVENUE SOUTH		
GOLDEI				ł	HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	incontinent of bowe indicated resident of and seizure disorde 7/27/15, indicated F and bladder and rea- toilet. During interview on stated "we normally room because it is bars and can do the stated, "There has the toilet just in fror careful when we op into the room." On 11/3/16, at 3:58 stated, "He would b him in the bathroon someone could see lost and close the of During interview on director of nursing s needed to maintain further stated she w not a curtain in fron room on the Alzheir one there. The facility Incontin 1/26/15, directed st privacy." The facility Dignity p indicated "All reside and in an environm enhances each res	el. In addition, R44's MDS diagnoses included dementia er. R44's care plan dated R44 was incontinent of bowel quired assist of one to use the 11/3/16, at 10:04 a.m. NA-A y bring [R44] to the shower safer. [R44] can use the grab e work himself." NA-A further never been a curtain around at of the shower. We try to be been the door but you can see p.m. family member (FM)-B be upset if someone could see n. If he were aware that e him, he would tell them to get	F 2	241			

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		AND HUMAN SERVICES			FORM	01/04/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		245293	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
GOLDEN	I LIVINGCENTER - HO	OPKINS		25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 246 SS=D	enhances each res improves his or her quality of life." Polic maintain dignity by care in a dignified n residents forward in appliances attached residents are not ex 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the n services in the facil accommodations o preferences, excep	ty and respect maintains and ident's self-worth and psychosocial well-being and y further instructed staff to "Assisting residents in daily nanner (e.g., pushing n wheelchairs, covering d to resident, ensuring kposed)." ONABLE ACCOMMODATION ERENCES	F 241 F 246			12/13/16
	by: Based on observative review, the facility for within at reach for 2 who were at risk for observations. Findings include: R74's annual Minim 10/3/16, indicated F cognition and was a make his needs un- indicated resident r activities of daily liv	NT is not met as evidenced tion, interview, and document ailed to ensure call lights were of 4 residents (R74, R54) r falls during random num Data Set (MDS) dated R74 had severely impaired able to understand others and derstood. R74's MDS needed assistance with all ing and diagnoses included is), arthritis and Alzheimer's.		The call lights are placed and are we reach for residents R74 and R54. The call lights will be placed and we reach for all residents residing in the facility. All nursing staff, housekeeping st social service staff and maintenance have been re-educated on the requirement to place and keep call within resident reach. Monitoring to ensure compliance conducted through random call light placement audits. The facility QAPI committee will re the call light placement audits quart	within e aff, e staff lights will be t eview	

Facility ID: 00872

		AND HUMAN SERVICES			FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY IPLETED
		245293	B. WING			C 03/2016
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 246	Continued From pa During a random ok a.m. R74's call light of the bed. Register call light was not wit R74's fall Care Area 10/18/16, indicated being discussed bu and recall. R74's alteration in e care plan dated 9/2 call bell within reach use call bell as need initiated 9/22/16 ins or personal items at provide reacher. During interview on stated R74 seldom During interview on assistant (NA)-F sa call light." R54's quarterly MD R54 had moderately sometimes able to b indicated R54 want communicate with b	Ige 11 Deservation on 10/31/16, at 7:22 t was observed down the back red nurse (RN)-D verified that thin R74's reach. A Assessment (CAA) dated R74 was aware of what was t had problems with memory elimination bowel and bladder 2/12, instructed staff to ensure h and provide reminders to ded. Fall risk care plan structed staff to have call light vailable and in easy reach or 10/31/16, at 7:22 a.m. RN-D used the call light. 10/31/16 at 7:26 a.m. nursing id "oh yes [R74] can use his S dated 10/7/16, indicated y impaired cognition and was understand others and be understood. R54's MDS	TAG F 246	DEFICIENCY)		
	of daily living.	assistance with all activities ated 1/25/16, indicated R54				

		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	in activities of daily 1/22/15, indicated F instructed staff to h available and in eas On 11/1/16, at 1:22 service (DSS) and a up an initial intervie line translator. DSS room but could not a portable phone. F lying on the floor ne in bed. DSS called handed the phone f light up and give it t to R54's room to se At 1:38 p.m. survey call light. NA-F verif NA-F did not check exiting the room. At interview with R54, without moving it. N and verified call ligh R54's reach. NA-G Call Light, Use of p indicated the purpo to resident's call for system is in proper further instructs sta residents be sure to conveniently for the resident where the him/her how to use	eased risk for falls and decline living. R54's care plan dated R54 was at risk for falls and ave call light or personal items sy reach. p.m. the director of social surveyor entered R54 to set w with R54 using the language blooked for the phone in R54's find it. DSS went and obtained R54's call light was observed ext to R54's bed. R54 was lying R54's family on the phone and to R54. DSS did not pick call to R54. DSS had NA-F come er if R54 needed assistance. For asked NA-F if R54 used the fied R54 used the call light. call light location prior to t 1:52 p.m. after completing surveyor put on the call light IA-G answered the call light the was on the floor and out of gave the call light to R54. rocedure reviewed 10/11/16, se was "to respond promptly assistance. To ensure call working order. Procedure ff "when providing care to oposition the call light a resident to use. Tell the call light was and show the call light. "Be sure all call the bed at all times, never on	F	246			
F 278			F 2	278			12/13/16

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PF		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. BOILD			(C
		245293	B. WING			11/0	03/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 278	Continued From no	ao 10		70			
SS=D	Continued From pa	ge 13 RDINATION/CERTIFIED	F 2	/8			
00-0	ACCONACT/COOL						
		ust accurately reflect the					
	resident's status.						
		must conduct or coordinate					
	each assessment w participation of heal						
	participation of near	un professionais.					
		must sign and certify that the					
	assessment is com	pleted.					
	Each individual who	completes a portion of the					
		ign and certify the accuracy of					
	that portion of the a	ssessment.					
		d Medicaid, an individual who					
		gly certifies a material and resident assessment is					
		oney penalty of not more than					
	\$1,000 for each ass	sessment; or an individual who					
		gly causes another individual and false statement in a					
		nt is subject to a civil money					
	penalty of not more	than \$5,000 for each					
	assessment.						
	Clinical disagreeme	ent does not constitute a					
	material and false s	statement.					
		NT is not met as evidenced					
	by: Based on observat	ion, interview, and document			The MDS for resident R48 has bee	'n	
		ailed to ensure the Minimum			corrected to accurately reflect the d		
	Data Set (MDS) wa	s correctly coded for 1 of 2			status.		
	(R48) residents rev	lewed for dental.			The MDS assessment for all resid will accurately reflect their dental st		
	Findings include:				The MDS nurses have been		

Facility ID: 00872

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING				C)3/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				72	25 SECOND AVENUE SOUTH		
GOLDEN	I LIVINGCENTER - HO	DPKINS		н	IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From part R48 admission MD had severely impain eat independently a MDS indicated R48 coronary artery dise Alzheimer's. In add did not have any de During observation was noted with no t During interview on registered nurse (R teeth or dentures. -At 2:16 p.m. licens reviewed prior facili admission assessmes says but he did not On 11/2/16, at 2:21 resident assessmes MDS and documen you mark it none of means he has teeth marked none of the has dentures or tee indicated he has up admission assessme does not address d within our reference not accurate. If it [M it would have trigge had to address the the care plan would	ge 14 S dated 6/3/16, indicated R48 red cognition and was able to offer set up by staff. R48's 's diagnoses included ease, diabetes and ition the MDS indicated R48 ental issues on 11/1/16, at 2:30 p.m. R48 eeth or dentures in his mouth. 11/2/16, at 1:51 p.m. N)-D verified R48 did not have ed practical nurse (LPN)-C ty discharge paper work and nent and stated "I know what it come here with dentures." p.m. RN-E, director of nt reviewed R48's admission tation in chart. RN-E stated, "If the above were present that n or dentures. His MDS is a above, making you think he th. The transfer summary oper and lower teeth. The nent indicates no teeth and entures. The nutrition note is a period. I guess my MDS is IDS] had been coded correctly red a CAA and I would have issue." RN-E further stated, I address diet, direct staff to ry mouth, and infections that	1	278		each AA as e the ed will be S the eview	
		11/3/16, at 1:44 p.m. the					

		& MEDICAID SERVICES				OMB	0RM APPROVE NO. 0938-039
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	TIPLE CONSTRU		(X3)	DATE SURVEY COMPLETED
		245293	B. WING				C 11/03/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADD	RESS, CITY, STATE, ZIP CO	DDE	
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECONI HOPKINS,	D AVENUE SOUTH MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EA	PROVIDER'S PLAN OF COF CH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 278	Alzheimer's care ur "We did not do den [guardian] sign a de admitted." The gua able to get dentures not document that d During document that "Discharge summa 5/27/16, indicated F dentures at time of summary requester -Clinical Health Sta indicated R48 had presence of denture -Nutrition Data shee had Swallowing dis "no teeth -has dent Nutritional assessm R48 did not have te dentures were brok message for the din if R48 could get an get dentures fixed, - R48's MDS dated status part 0200b, v natural teeth or too R48 did not have a The facility RAI (res Process Policy date Living Centers will of Medicare and Medi completion and cor	hit director (ACUD) stated, tal referral or have her ental form when [R48] was rdian told me R48 was not s." ACUD acknowledged, "I did conversation." eview the following were ry from previous facility dated R48 had upper and lower discharge. Copy of discharge d but not received. tus form dated 5/27/16, "No teeth" and did not address	F 2	78			

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		AND HUMAN SERVICES			F	ORM	01/04/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	COM	E SURVEY PLETED
		245293	B. WING				C)3/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	0,2010
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 282 SS=D	dentures can promo self-image and pers enhancing social in and medication-rela may increase a res complications such communication def addressed a reside discomfort, and cor 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b	ote a resident's positive sonal appearance, thereby teractions. Medical illnesses ated adverse consequences ident's risk for related as impaired nutrition and icits. The dental care CAA nt's risk of oral disease, mplications. RVICES BY QUALIFIED		278			12/13/16
	by: Based on observat review, the facility ficture was implement residents (R28) rev living (ADLs), failed (R52) to the toilet in toileting plan, and ficture repositioning and st (R52) reviewed for Findings Include: R28 was observed have black facial has mouth. On 11/1/16,	NT is not met as evidenced tion, interview and document ailed to ensure the plan of need for shaving for 1 of 3 iewed for activities of daily d to assist 1 of 2 residents accordance with their failed to prevent non-pressure down related to lack of hearing for 1 of 4 residents wheelchair positioning. on 10/31/16 at 1:42 p.m., to air on the right edge of her at 12:23 p.m. the black facial he right side of R28's mouth.			The resident, R28, has had facial hair removed. The resident, R52, has rece toileting and repositioning in accordan with plan of care. The non-pressure sl alteration for resident, R52 has resolve All residents residing in the facility w have facial hair removed unless reside preference states otherwise. All reside will be toileted and repositioned in accordance with the plan of care. All nursing staff have been re-educa on the requirement to remove facial ha from all residents unless resident preference states otherwise. All nursing staff have been re-educated on the requirement to toilet and reposition all residents in accordance with the plan care.	eived ice kin red. rill ent ents ated air ng	

Facility ID: 00872

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		IPLETED
		245293	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		03/2010
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 282	On 11/3/16, at 7:19 was observed to as changed R28's inco assisted R28 to ge comb the resident's table in the small d that time, R28 was 1/2 inch long hairs On 11/3/16, at 9:05 provide person hyg for R28. The NA dia removal of the blac side of her mouth. R28's care plan ide assist R28 with per During interview on R28 was asked abd lady does not have hair?" During interview on said, "She accepts shave her today. I we mustache. I norma days depending on every morning whe needed. I should ha R52 was observed dining room reading slouched part way knees above the to at approximately 48 higher than hips. R	a.m. nursing assistant (NA)-C ssist R28 with adl's. NA-C ontinence product, then t dressed, wash face and s hair. NA-C then took R28 to a ining room for breakfast. At observed to have eight black on the right side of her mouth. a.m. NA-C was obsesrved to iene care, incontinence care d not identify or assist R28 with k 1/2 inch hairs on the right	F 28	82 Monitoring to ensure comp conducted through weekly of audits and weekly observati toileting and repositioning to accordance to the plan of ca The facility QAPI committe the grooming and the obser toileting and repositioning au for further recommendations The date of completion wi	rooming onal audits of ensure are. ee will review vational udits quarterly s.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IB NO. 0938-0391	
		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245293			C 11/03/2016	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - HOPKINS		725 SECOND AVENUE SOUTH		
		HOPKINS, MN 55343		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
 F 282 Continued From page 18 walked through the dining room and spoke with other residents. -7:32 a.m. nursing assistant (NA)-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees remained higher than the table top. -8:14 a.m. R52 pushed himself-back from the dining room table. -8:21 a.m. RN-K checked R52's foot rest and adjust his feet. -8:24 a.m. Breakfast meal was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top. -9:03 a.m. licensed practical nurse (LPN)-D wheeled R52 to the small dining room and positioned him at a table. R52 was positioned upright at the table with both knees lying to the left the table top. -9:05 a.m. R51. RN-D reclined Broda chair part way without telling R52 she was going to recline him. R52's eyes went wide open and R52 opened his mouth wide and upper body stiffened. RN-D wheeled R52 to the main dining room. -9:54 a.m. R52 was sitting in Broda chair at table playing cards by his self. R52 was sliding part way down in chair. The Broda chair was in an upright position. -10:52 a.m. R52 sitting in chair playing cards. Position unchanged with R52 slouched down in the chair. -10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute. -11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and 	F 2			

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ICES			APPROVED 0938-0391
R/CLIA (X2) MU		(X3) DAT COM	E SURVEY PLETED
B. WIN	G		C 03/2016
	STREET ADDRESS, CITY, STATE, ZIP CODE		
	725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
FULL PREI	FIX (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
-C said, two stants nch. I am ssume it ve done it and left mission ded to tained tained a Z stand ds and nat they tand belt took m R52's at brief. h urine. t seat and nroom to ed him ted him d every m when oody A-A and	282		
	R/CLIA (X2) MI ABER: A. BUIL B. WIN S ID FULL PRE TION) TA	R/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	RICLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT A BUILDING

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
245293		B. WING			C 11/03/2016			
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
GOLDEN	N LIVINGCENTER - HO	OPKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 282	At 11:57 a.m. RN-D R52's scrotum and (cm.) long by x 0.5 was too shallow to is said that was a new to call it a Stage two (Partial-thickness lo dermis. The wound moist, and may also ruptured serum-fille and R52 sliding in t R52's OT-Therapis: Summary dated 7/2 caregiver education [wheelchair] in uprig hips in wch every 1- unable to initiate se impairment and rec activities out in fron agitation." R52's Swallowing D Swallow study care staff to ensure prop self-care deficit care 9/21/16, to toilet R5 survey process alte to impaired physica incontinence preser risk for scrotum she R52's significant ch Data Set (MDS) dat both short and long diagnoses of deme (loss of movement failure to thrive. R52	measured the wound on stated it was 1.5 centimeters cm. wide. RN-D said the depth measure. RN-D and LPN-C wound and they were going pressure ulcer bes of skin with exposed bed is viable, pink or red, present as an intact or ed blister) due to prolong sitting	F 2	282				

		AND HUMAN SERVICES			FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245293	B. WING		C 11/03/2016	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	N LIVINGCENTER - HO	OPKINS		25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	transfers and bed r incontinent of bowe identified R52 was skin was intact. The Treatment Adm 11/1/16 through 11/ be repositioned eve The date of the ord During an interview said, "We reassess assistant director o wound is caused by pressure ulcer. The cream, off loading/r ordered a low air lo shearing was cause with the EZ stand." considered the slid knees as possible o requested hospice evaluate him for po During interview on said, "[R52] tries to in pain or is wet. If I knees above the ta after we boosted hi During interview wit at 11:39 a.m. DNS NA-B had admitted when he should ha was not deliberate I Office of Health Far suspended NA-B u investigation, becau	nobility and was always at and bladder. R52's MDS at risk for skin breakdown and aninistration Record dated 30/16, indicated R52 was to ery two hours and as needed. er was 4/9/15. 11/2/16, at 2:03 p.m. LPN-C sed the wound with the f nursing (ADNS) and the y shearing and is not a e treatment will be barrier reposition every hour. I have ss mattress. We believe the ed when they transferred [R52] LPN-C said "We did ing in the Broda chair and high causes of shearing and have have their Physical Therapist sitioning."	F 282			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
		245293	A. BUILDING			C		
NAME OF F	PROVIDER OR SUPPLIER	240200			TREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2016		
	I LIVINGCENTER - HO	JEKING		7	25 SECOND AVENUE SOUTH			
GOLDEN		JEKING	HOPKINS, MN 55343					
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	said, "I went and re educator and LPN-(after lunch. The RN determined it looked traumatic injury. R5 and his scrotum is of The ADNS said, "He and then standing w it was such frank bl the transfer." The D is not wound certific educator. The DNS ensure residents wo and would not be sl their wheelchairs. T expected staff to er upright while eating During interview on said, "R52 sits forw he is trying to pull h During interview on occupational therap usually provided the stated therapy had positioning. "We red repositioning of hips	assessed with our RN clinical C. We reassessed R52 right I clinical educator and I d more like a shearing 22 is in a reclining wheel chair quite edematous and large." e slid down during the transfer with the standing lift. Because ood we feel it occurred during DNS also confirmed the ADNS ed nor is the RN clinical is stated she expected staff to ould be positioned properly liding repeatedly or leaning in The DNS further stated she nsure residents were sitting 1. 11/3/16, at 1:29 p.m. LPN-D rard a lot. He almost looks like	F 28	82				
F 309 SS=E	483.25 PROVIDE 0	CARE/SERVICES FOR EING	F 30	09			12/13/16	
	provide the necessa or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment						

Facility ID: 00872

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245293	B. WING	B. WING			C 11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				72	25 SECOND AVENUE SOUTH			
GOLDEN	I LIVINGCENTER - HO	JPKIN5		Н	OPKINS, MN 55343			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Continued From pa and plan of care.	ge 23	F3	309				
					The residents, R56, R52, R21 and have been evaluated for wheelchai positioning needs and adjustments been put into place as required. All residents residing in the facility evaluated for wheelchair positioning quarterly basis and as needed to en- proper wheelchair positioning. Therapy staff have been re-educate the requirement to conduct quarterly wheelchair positioning evaluations. nursing staff have been re-educate the requirement to observe residen wheelchair positioning and take not improper positioning which would ir improper body alignment, dangling sliding in chair, reclined seating at r in conjunction with improper table h Monitoring to ensure compliance conducted through random observa wheelchair positioning audits. The facility QAPI committee will r the wheelchair positioning audits qu for further recommendations. The date of completion will be 12	r have y will be g on a nsure ated on ly All d on t te of nclude of feet, meals neights. will be ational eview uarterly		

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A: BOILDING C 245293 B. WING 11/03 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/03 GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 HOPKINS, MN 55343 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	SURVEY LETED
A: BOILDING C 245293 B. WING 11/03 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/03 GOLDEN LIVINGCENTER - HOPKINS STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	;
245293 B. WING 11/03 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH GOLDEN LIVINGCENTER - HOPKINS HOPKINS, MN 55343 HOPKINS, MN 55343 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 HOPKINS, MN 55343 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	
GOLDEN LIVINGCENTER - HOPKINS HOPKINS, MN 55343 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(XE)
DEFICIENCY)	(X5) COMPLETION DATE
F 309 Continued From page 24 F 309	
 On 11/2/16, at 7:20 a.m. R56 was observed in the large dining room slouched part way down in high back tilt in space wheelchair. R56's body angled from left to right with legs dangled to right side off wheelchair. -At 7:30 a.m. the director of nursing services (DNS) walked through the dining room adjusted R56's glasses, spoke briefly to resident and left never offered to adjust resident position. -At 7:32 a.m. nursing assistant (NA)-A approached resident at the dining table offered a clothing protector however, never offered to adjust resident position even though the legs were still dangling. -At 7:44 a.m. 08:06 a.m. resident remained in the same position seated on wheelchair several staff in the area none offered to position resident. -At 8:20 a.m. N-56 was still sitting angled left to right feet dangling off the right side of wheelchair and a plate of food was in front resident on the table. -At 8:29 a.m. NA-A and NA-B approached resident then reclined wheelchair and lifted resident their bair back. During the back and existent was not extended and resident feet were dargling. -At 8:55 a.m. NA-A approached R56 reclined the Broda wheelchair the at 45 degrees legges angle then put the footrest down, put resident feet were dargling. -At 8:55 a.m. NA-A approached R56 reclined the Broda wheelchair to a 45 degree reclining. -At 9:38 a.m. resident two sobserved asleep at the end of the hall across from small dining room reclined at 56 degrees legs dangling off to the fight space half back to be a figure from the sole from the side of the side for the net and wheeled resident to a figure figure for the net and the side end of the hall across from small dining room reclined at 56 degrees legs dangling off to the 	

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING				C D3/2016
NAME OF	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	-At 9:43 a.m. the ac resident never offer -At 9:43 a.m. licens approached R56 ar bed. LPN-C stated however left the fee hips were observed -At 9:51 a.m. LPN- NA-D wheeled resid On 11/3/16, at 9:17 seated on the Brod watching television tilted at approximat bottom was slumpe seat close to the ec side of the folded for -At 9:20 a.m. NA-A acknowledged resid wheelchair and indi needed to lay resid resident always did the nurses knew ab had tried three diffe however still was sl On 11/3/16, at 9:34 therapist (OT)-A rev indicated the last tin OT-A was in 8/10/1 OT-A verified three the medical record assessment for pro On 11/3/16, at 3:47 rehabilitation stated occupational therap	red to re-position resident. ctivities assistant walked past red to re-position. bed practical nurse (LPN)-C nd offered resident to go to she was going to adjust feet et still dangling and resident d off center to the right. C returned with NA-A and dent into the room. a.m. R56 was observed a wheelchair in the room . The wheelchair was slightly ely 30 degrees, and resident ed down on the wheelchair dge, legs hanging to the right potrest. and NA-C came into the room dent was sliding out of the cated that was why they ent down. Both NA's indicated slide down the wheelchair and pout it and thought the facility erent wheelchairs with resident iding down. a.m. the occupational viewed the medical record and me resident had been seen by 6, for a broken wheelchair. was no notes or order were in for the need to do a full		309			

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING	i			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	was to reposition as resident down if res rehabilitation indica to identify a change significant change v for orders to treat [F rehabilitation furthe locate the quarterly this year however w medical records. On 11/3/16, at 4:18 been seen for a bro positioning. LPN-C his feet on the side supposed to reposit the care plan did no stated she would be occupational therap positioning. On 11/3/16, at 4:45 rehabilitation verifie occupational therap for wheelchair posit forward she would de done consistently to were properly positi R52 was observed was in the dining ro R52 was slouched p with knees above th hips were at approx knees higher than h pedals. -7:30 a.m. the DNS	s needed and staff was to lay stless. The director of ted, "we do quarterly screens and if we identified a we then would ask the doctor R56]." The director of r stated she was not able to screening for R56 from March vas going to check with p.m. LPN-C state R56 had oken wheelchair armrest not acknowledged R56 did dangle and stated the staff were tion resident. LPN-C verified of address the positioning and e obtaining an order for by to evaluate R56 for p.m. the director of ed there was no quarterly by screens completed for R56 tioning. She indicated moving ensure quarterly screens were o make sure the residents ioning in the wheelchairs. on 11/2/16, at 7:20 a.m. and oom reading the newspaper. part way down in Broda chair, ne top of the table top. R52's kimately 45 degree angle with hips. R52's feet were on foot a walked through the dining th other residents and did not	F	309			

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	à	COM	IPLETED
		245293	B. WING				C 03/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	I LIVINGCENTER - HO	NEKINS		7	725 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - HC			H	HOPKINS, MN 55343		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX			PREFIX		(EACH CORRECTIVE ACTION SHOUL		COMPLETION DATE
TAG	REGULATIONT ON L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)		67.112
	 I						
F 309	Continued From pa		^	000			
1 000		-	F 3	09			
		ered R52 a clothing protector.					
		R52's wheelchair positioning.					
		ed nurse (RN)-K with Asera R52 out of the dining room.					
		turned R52 to the dining room					
		a magazine. R52's knees					
	were higher than th						
		shed self-back from dining					
	room table.	shed boll back normaling					
		necked R52's foot rest and					
	adjust his feet.						
		st was placed in front of R52.					
		's chair so R52's knees were					
	not above the table						
	-9:03 a.m. LPN-D w	vheeled R52 to the small					
		sitioned him at a table. R52					
		ght at the table with both					
	knees lying to the le						
		eclined Broda chair part way					
		she was going to recline him.					
		de open and R52 opened his					
		per body stiffened. RN-D					
		main dining room for an					
	activity.	- sitting in Drada abair at tabla					
		s sitting in Broda chair at table					
		s self. R52 was sliding part The Broda chair was in an					
	upright position.	THE DIVUA CHAIL WAS III AH					
		ting in chair playing cards and					
		changed as R52 was					
	slouched down in th						
		es assistant-A moved R52 to					
		p and had R52 hold on to					
	strap of the parachu						
		was interviewed as to how					
	frequently R52 was	to be toileted and					
		the Broda chair. LPN-C said,					
		d and changed every two					
	hours I will have to	ask the nursing assistants					

If continuation sheet Page 28 of 56

		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	when he was last c -11:27 a.m. NA-A b room to locate a lift -11:30 a.m. NA-A re wait for a lift as they -11:36 a.m. NA-A a mechanical lift. -11:38 a.m. NA-A a because R52 was a -11:39 a.m. NA-A a put gloves on. NA-A were doing. NA-A a and lifted R52 to a R52 into the bathro pants and removed NA-B indicated the NA-B lowered R52 their hands. Staff et R52 privacy. -11:49 a.m. LPN-C he was standing in red bloody area not NA-A and NA-B to p RN-D to assess an At 11:57 a.m. RN-D R52's scrotum and (cm.) long by x 0.5 was too shallow to said that was a new to call it a stage two (partial-thickness lo dermis. The wound moist, and may also ruptured serum-fille visible and deeper f Granulation tissue,	hanged." rought R52 to room and left and sling. eturned and said needed to y only had one lift. nd NA-B entered with a nd NA-B left to get EZ stand an EZ stand transfer. nd NA-B washed hands and A explained to R52 what they and NA-B put on EZ stand belt standing position and took om. NA-B pulled down R52's I the soiled incontinent brief. pad was very wet. NA-A and to the toilet seat and washed xited the bathroom to allow checked R52's bottom when the EZ Stand. There was a ted on scrotum. LPN-C asked put R52 in bed and then go get d measure the wound. D measured the wound on stated it was 1.5 centimeters cm. wide. RN-D said the depth measure. RN-D and LPN-C v wound and they were going		09			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
			/		~	(C
		245293	B. WING			11/0	03/2016
NAME OF F	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			725 SECOND AVENUE SOUTH		
					HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTIO		0(5)
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIALE	DATE
			1				
F 309	Continued From pa	ge 29	F 3	809			
		ange of condition MDS dated					
		52 had both short and long ems and diagnoses of					
		nritis, hemiplegia (loss of					
		side of the body) and failure to					
		ndicated R52 required ssing toileting, transfers and					
	bed mobility and wa	as always incontinent of bowel					
		MDS identified R52 was at					
	risk for skin breako	own and skin was intact.					
		tinence CAA dated 4/15/16,					
		dependent on staff for toileting moisture related skin break					
		e ulcer CAA dated 4/15/16,					
	indicated R52 was	at risk for worsening skin					
		essure ulcers. The Care Area most recent comprehensive					
		were requested but not					
	provided.						
	B52's Swallowing D	Difficulty as related to Abnormal					
	Swallow study care	plan dated 10/6/15, instructed					
		er positioning at meals. R52's					
		e plan instructed staff on 2 every two hours. During the					
	survey process, the	alteration in skin integrity					
		physical mobility, bowel and					
		e, and the presence of scrotal or scrotum shearing care plan					
	were initiated.	U					
	The Treatment Adm	ninistration Record dated					
		30/16, indicated R52 was to					
		ery two hours and as needed.					
	The date of the ord	er was 4/9/15.					
		Progress & Discharge 29/15, indicated, "Provided					

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		AND HUMAN SERVICES				FORM	APPROVED
				וחוד			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
			AL BOILD			(C
		245293	B. WING				03/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH		
				ŀ	HOPKINS, MN 55343		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 200							
F 309	Continued From pa	-	F 3	309			
		on recommendations for wch ght alignment, Repositioning of					
		gni aignineni, nepositoring or					
		-2 hours due to pt [patient]					
		condary to cognitive					
		commendation for leisure to f pt on tables to reduce					
	agitation."	t of pt of tables to reduce					
	0						
		11/02/16 at 11:23 a.m. LPN-C					
		unch. I am going to have it e I assume it should have					
	0	nould have done it after					
	breakfast."						
	D destates to 44						
		/2/16, at 11:48 a.m. NA-B said, him sliding down in the chair.					
		m since before breakfast he is					
	to be toileted every						
	Duning interview 44	(0/10, at 0:00 a at 1 DN 0					
		/2/16, at 2:03 p.m. LPN-C ed the wound with the					
	-	f nursing (ADNS) and the					
		/ shearing and is not a					
	•	treatment will be barrier					
		eposition every hour. I have					
		ss mattress. We believe the ed when they transferred [R52]					
		LPN-C said "We did					
	considered the slidi	ng in the Broda chair and					
		ible causes of shearing and					
	have requested hos therapist evaluate h	spice have their physical					
	inciapisi evaluate f						
		11/3/16, at 10:04 a.m. NA-A					
		move sometimes when he is					
		ne was at the table with his ble we should have sat him up					
	after we boosted hi						

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. BOILDI			(C
		245293	B. WING			11/0	03/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	DPKINS					
				r	HOPKINS, MN 55343		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI)	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			1		,		
F 309	Continued From pa	ge 31	F 3	09			
		0	_				
		th DNS and ADNS on 11/3/16,					
		said they met with NA-B and he had missed checking R52					
		ve. The DNS said, "He felt it					
		but I did report it to OHFC (the					
		cility Complaints) and ntil we complete the					
		use it could be construed as					
		ulnerable adult act. The ADNS					
		assessed with our RN clinical					
		C. We reassessed R52 right I clinical educator and I					
		d more like a shearing					
		2 is in a reclining wheel chair					
		quite edematous and large." e slid down during the transfer					
		with the standing lift. Because					
	it was such frank bl	ood we feel it occurred during					
		NS also confirmed the ADNS					
		ed nor is the RN clinical staff to					
		ould be positioned properly					
		liding repeatedly or leaning in					
		he DNS further stated she neuronation in the base of the state of the					
	upright while eating						
		11/3/16, at 1:29 p.m. LPN-D					
	he is trying to pull h	ard a lot. He almost looks like					
		11/3/16, at 4:29 p.m.					
		bist (OT)-B said hospice					
		e Broda chairs. OT-B also seen R52 in July of 2015, for					
		commended frequent					
	repositioning of hips	s as needed." OT-B said, "It					
	would not be appro	priate to have R52's knees					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY
	045000					с
NAME OF PROVIDER OR SUPPLIER	245293	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/	03/2016
				25 SECOND AVENUE SOUTH		
GOLDEN LIVINGCENTER - HO	JPKINS		Н	IOPKINS, MN 55343		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309 Continued From pa above the table."	ge 32	F3	309			
 was severely cognit understood others, for transfers, bed m personal hygiene al required supervisio indicated R21's diag chronic kidney dise chronic obstructive experienced cough was on hospice. Pressure Ulcer CAA required assistance mobility needed a s wheelchair to reduce Pressure ulcer actu 11/3/16, instructed a reducing wheelchai repositioning per as impaired physical m staff "Wheelchair us hospice, staff to pro- unsafe food related recommended diet liquids care plan die mechanical soft hon evidenced by cougn needing staff super therapy recommend to follow with each speech therapy not 	S dated 8/1/16, indicated R21 tively impaired, sometimes and was dependent on staff hobility, dressing, toileting, nd wheel chair mobility. R21 n when eating. R21's MDS gnoses were dementia, ase, depression, anxiety, pulmonary disease and ing/choking during meals. R21 A dated 2/25/16, indicated R21 e with transfers and wheelchair special seat cushion in ce or relieve pressure r al or at risk care plan printed staff to provide pressure r cushion and turning and ssessment. Potential for nobility care plan instructed se, wheelchair is provided by opel resident. " Intake of to speech therapy pureed pudding thicken et waiver signed allowing ney thickened liquids as ning with meals , resident vision with meals and speech dations for staff and resident meal. Recommendations from on the care plan. The Care s wheel chair positioning for					

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING	i			C 0 3/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEI	N LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	On 11/2/16, at 7:20 room sitting in a low chair was partially r degrees from uprig chair, R21's feet we ground. The table t R21 was wearing b -7:30 a.m. the DNS room. -8:20 a.m. staff pla eggs, waffles, and c chair position uncha -8:32 a.m. R21 wa and choking. NA-A table and stayed wi clear his throat. LP before putting anot chair remained rect at mid chest level. -8:51 a.m. R21 had to cause R21 to pu -8:59 a.m. NA-A rol with feet dangling a inch. The OT-Therapist f Summary dated 1/2 [inch] wide x 16" de high right arm rest, cushion with slight for pt [patient] to ha and solid heel conta and to reduce risk f Facilitated and prov wheelchair mobility seat wheelchair. Facilita	a.m. R21 was in the dining v Broda chair. The back of eclined back about 15 ht. There were no foot rests on ere dangling just above the op was at R21's nipple line. lue anti slip socks. S walked through the dining ced breakfast of scrambled patmeal in front of R21. Wheel	F	309			

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	with wheelchair mo wheelchair position During interview on DNS stated she exp residents would be not be sliding repeat chairs. DNS stated proper body alignm the residents were During interview on said R21 coughed a signed a diet wavie was aware of the co notice [R21's] chair yesterday. Today hi his chair upright. [R for meals and the ta right height so he c During interview on said hospice usuall Therapy saw R21 co was in a 16 inch wie was 14 inch from th chair was 16 inches self-propelling the v residents were not than the residents f did not do a wheelco chair."	d for increased independence bility." Requested most current ing assessment, no other ing assessments provided. 11/3/16, at 11:39 a.m. the pocted staff to ensure positioned properly and would atedly or leaning in their wheel expected staff to ensure ent in the wheelchair and that sitting upright while eating. 11/3/16, at 1:38 p.m. LPN-D all the time. His family had r for quality of life. Hospice bughing. LPN-D said, "I did not was reclined at breakfast s chair was reclined so I lifted i21] should be sitting upright able should be lowered to the	F	309			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	PKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	vision. R100's MDS dependent on staff and was incontinen MDS indicated R10 diagnoses of deme depression. Progres indicated R100 had Pressure Ulcer CA/ R100 was totally de using a mechanical cushion in wheelchai pressure Alteration in skin int 11/3/16, instructed a reducing wheelchai reposition according On 11/02/16, at 7:21 R100 into the main slouched down in B incontinence produc and R100's abdome were falling outward right shoulder was I leaning to the left in -7:30 a.m. the DNS and stopped and sp -7:40 a.m. LPN-C a incontinence produc -8:07 a.m. R100 in crying. R100's shou and knees falling ou- -8:09 a.m. NA-D sp clothing protector. -8:22 a.m. LPN-D s adjusting R100's po	 indicated R100 was for all activities of daily living, t of bowel and bladder. R100's 0 was on hospice and had ntia, hypertension anxiety and ss note dated 10/26/16, a stage two pressure ulcer. A dated 12/31/15, indicated pendent on staff for transfers lift, and needed a special seat air to reduce or relieve egrity care plan printed staff to provide pressure r cushion and turn and g to schedule and as needed. 0 a.m. unidentified NA brought dining room. R100 was sitting roda chair. R 100's ct was sticking out of the pants en was exposed. R100's legs d to the left and right. R100's nigher than left and R100 was the Broda chair. walked through dining room ooke to R100. djusted R100's shirt so the ct not seen. same position with intermittent ulders still angled to the left utwards with feet on foot rest oke with R100 and applied a 	F 3	809			

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY IPLETED	
						(С	
		245293	B. WING			11/0	03/2016	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - HO	OPKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE	
			1		DEFICIENCY)			
F 309	Continued From pa	ae 36	F 3	309	9			
	room.	5						
		bught mechanical; lift into						
	R100's room to trar crying.	nsfer R100 to bed. R100						
	OT-Therapist Progr	ess & Discharge Summary						
	dated 11/21/14, indi	icated, "Significant progress						
		safe sitting in customized neals. Functional progress this						
		nificant due to issued						
	personalized/custor	nized 18" wide kyphotic						
		degree dump slight saddle cushion with armrest bolsters						
		armrest, lateral trunk supports,						
		sts in order to decrease risk of						
		omfort during meals." Irrent wheelchair positioning						
		her wheelchair positioning						
	assessments provid	ded.						
	During interview on	11/2/16, at 9:13 a.m. NA-A						
		ave been repositioned during						
	breakfast because	she looked uncomfortable.						
		erview on 11/3/16, at 10:04						
		hen [R100] cries she will						
	repositioned every t	hair. [R100] is turned and two hours."						
	. ,							
		11/3/16, at 11:39 a.m. DNS						
		erly and would not be sliding						
	repeatedly or leaning	ng in their wheel chairs. DNS						
		Iff to ensure proper body eelchair and that the residents						
	were sitting upright							
		-						
		11/3/16, at 1:26 p.m. LPN-D tracted as her legs do not						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/04/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245293	B. WING				C 03/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	extension mode R1 back up. LPN-D said bolster but it does r use a pillow to keep During interview on said hospice usually Therapy saw R100 placed in an 18 inch wheelchair and had trunk supports and was unable to say w wheelchair was rep did not do a wheelc chair." Wheel chair positio provided Wheelcha 2/26/16. Procedure provide mobility for with safety and corr staff that "Many type available. Follow the for each type of whe instructed staff to "L on the foot rests if u good body alignment address upper body appropriate type or Broda Seating Ope instructs facility staff exclusively for resid institutions who are caregivers. The suit be determined by a familiar with the seat	he legs are placed in the 00 would contract them right d, "Usually we use the side not work well so sometimes we b her from falling to the left." 11/3/16, at 4:29 p.m. OT-B y provides the Broda chairs. in November 2014. She was a kyphotic high back a saddle cushion, lateral calf pads for her legs. OT-B when R100's customized laced with a Broda chair. "We hair assessment for the Broda ning policy requested. Facility ir use of procedure dated indicated the purpose was to the non-ambulatory resident of wheelchairs are e manufacturer's instructions eelchair." The policy further ower foot rest and place feet used. Position feet and legs in nt." The procedure did not y alignment or assessment for	F 3	09			

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM /	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	IG	0011	
		245293	B. WING _		11/0	03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH		
GOLDEN	I LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 311 SS=D	dangerous to the reparties, and can co the following: 1) Unauthorized op 2) Unauthorized op 2) Unauthorized mo 3) Inappropriate use who has not been a caregiver responsit 4) Failure to freque the chair." The repositioning p provided. 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given to services to maintain specified in paragra This REQUIREMEN by: Based on observator review, the facility fa 1 of 1 resident (R28 living who required Findings include: During random observed on right edge of mo	ty claims." proper use of the chair is esident, caregivers, or third nsist of, but is not limited to eration of the chair's functions. ovement of the chair. e of the chair for a resident assessed by a qualified ole for their seating. ntly reposition the resident in olicy was requested but not TMENT/SERVICES TO	F 30		nair y will sident ucated I hair nt will be	12/13/16

Facility ID: 00872

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	changed R28's inco R28 to get dressed R28's hair. NA-C to dining room for brea 1/2 inch long hairs of On 11/3/16, at 9:05 and performed inco was done R28 still f 1/2 inch hairs on the R28's activities of d assessment dated a assistance with grou R28's quarterly MD R28 was severely of diagnosis of demen pain. R28's MDS ind assistance with per- shaving. R28's physical func printed 11/3/16, inst personal hygiene. During interview on R28 was asked abo lady does not have hair?" During interview on said, " She accepts not shave her today little mustache. I no two days depending	a.m. nursing assistant (NA)-C ontinence product assisted and wash face. NA-C combed ok R28 to a table in small akfast. R28 had eight black on the right side of mouth. a.m. NA-C took R28 to room ontinence cares. When NA-C had approximately eight black e right side of mouth. aily living Care Area 4/6/16, indicated R28 required	F	311	The facility QAPI committee will r the grooming audits quarterly for fur recommendations. The date of completion will be 12	rther	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF F	PROVIDER OR SUPPLIER	2.0200			REET ADDRESS, CITY, STATE, ZIP CODE	11/0	J3/2010
GOLDEN	LIVINGCENTER - HO	PKINS			5 SECOND AVENUE SOUTH		
				НО	OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311		-	F 31	11			
F 312 SS=D	needed. I should ha 483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR	F 31	12			12/13/16
	daily living receives maintain good nutri and oral hygiene.	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review, the facility fa toilet who was dependent observation for whe Findings include: R52 was continuous 7:20 a.m. until 11:5 On 11/2/16, at 7:20 room reading the ne part way down in Brithe top of the table. pedals. -7:44 a.m. registere Care hospice took I -7:55 a.m. RN-K refitable and gave R52 -8:24 a.m. Breakfas had not left the dinin -9:03 a.m. licensed wheeled R52 to the positioned him at a	s observation on 11/2/16, from 7a.m. and the following noted: a.m. R52 was in the dining ewspaper. R52 was slouched roda chair, with knees above R52's feet were on foot ed nurse (RN)-K with Asera R52 out of the dining room. turned R52 to the dining room a magazine. st placed in front of R52. R52 ng room since 7:44 a.m. practical nurse (LPN)-D small dining room and			The resident, R52, has received to in accordance with plan of care. All residents residing in the facility toileted in accordance with their pla care. All nursing staff have been re-edu on the requirement to toilet all resid accordance with their plan of care. Monitoring to ensure compliance conducted through weekly observat audits of toileting to ensure accorda the plan of care. The facility QAPI committee will re the observational toileting audits qu for further recommendations. The date of completion will be 12-	y will be in of ucated lents in will be tional ance to eview iarterly	

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		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	dining room for an a -10:52 a.m. R52 sit Position unchanged the chair. R52 rema had not left the area -10:55 a.m. activitie the parachute group strap of the parachu -11:16 a.m. LPN-C frequently R52 was repositioned out of "[R52] gets checked hours I will have to when he was last c -11:27 a.m. NA-A b room to locate a lift -11:30 a.m. NA-A a wait for a lift as the -11:36 a.m. NA-A a mechanical lift. -11:38 a.m. NA-A a because R52 was a -11:39 a.m. NA-A a put gloves on. NA-A were doing. NA-A a and lifted R52 to a R52 into the bathro pants and removed brief. NA-B indicate and NA-B lowered washed their hands allow R52 privacy. R52's significant ch Data Set (MDS) da both short and long	activity. ting in chair playing cards. d with R52 slouched down in ained in the dining room and a. es assistant-A moved R52 to p and had R52 hold on to ute. was interviewed as to how to be toileted and the Broda chair. LPN-C said, d and changed every two ask the nursing assistants hanged." rought R52 to room and left and sling. eturned and said needed to y only had one lift. entered room and obtained	F 3	312			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TID			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. DOILD	ii vo	·	(С
		245293	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			ξ	STREET ADDRESS, CITY, STATE, ZIP CODE		
	I LIVINGCENTER - HO	OPKINS		7	725 SECOND AVENUE SOUTH		
GOLDEN				ŀ	HOPKINS, MN 55343		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
	1						
F 312		-	F 3	312		l	
		on one side of the body) and				l	
		2's MDS indicated R52 e with dressing toileting,				l	
		nobility and was always				l	
		and bladder. R52's MDS				l	
		at risk for skin breakdown and				l	
	skin was intact.					l	
	R52's urinary incon	tinence Care Area				l	
		dated 4/15/16, indicated R52				l	
	was dependent on a	staff for toileting and was at				l	
		lated skin break down.				l	
		A dated 4/15/16, indicated R52				l	
		sening skin break down and ne Care Area Assessment for					
		lated 9/6/16, were requested				l	
	but not provided.					l	
		the state of the s					
		icit care plan instructed staff R52 every two hours				l	
		ess R52's alteration in skin				l	
		mpaired physical mobility,				l	
	bowel and bladder i	incontinence presence of				l	
		at risk for scrotum shearing				l	
	care plan was initia	ted.				l	
	During interview on	11/2/16, at 11:23 a.m. LPN-C				l	
		unch. I am going to have it				l	
	done right now sinc	e I assume it should have				l	
		ng toileting of R52]. They				l	
	should have done it	t after breakfast."				l	
	During interview 11	/2/16, at 11:48 a.m. NA-B said,					
		him since before breakfast he					
	is to be toileted eve	ry two hours. "					
	D day taken to the						
		th DNS and ADNS on 11/3/16, aid they met with NA-B and					
		had missed checking R52					

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		AND HUMAN SERVICES			FO	ED: 01/04/2017 RM APPROVED VO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245293	B. WING	i		C 11/03/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From pa when he should ha	-	F	312		
F 371 SS=E	not provided. 483.35(i) FOOD PF	itioning policies requested but ROCURE, /SERVE - SANITARY	F	371		12/13/16
	considered satisfac authorities; and	om sources approved or story by Federal, State or local distribute and serve food ditions				
	by: Based on observat review, the facility f stored and prepare including: food prep maintained in good temperatures were ensure safe food st and an ice machine maintained in a sar potential to affect 1 facility who received areas. Findings include: On 10/31/16, at 7:0 tour, a Hobart large	NT is not met as evidenced tion, interview and document ailed to ensure food was d under sanitary conditions baration equipment was not repair, refrigerator not appropriately monitored to orage in 2 of 6 kitchenettes, e in 1 of 6 kitchenettes was not hitary manner. This had the 03 of 106 residents in the d their meals from the kitchen			The splash guard accessory on the Hobart mixer has been removed from the mixer. The door seal on the refrigerator the 2 East main dining room has been repaired and is intact. The 2 East main dining room refrigerator was reloaded properly and is now maintaining proper temperatures below 41 degrees. The 11 main dining room refrigerator has been reloaded properly and is now maintaining proper temperatures, below 41 degrees. The ice machine spout in the 2 East main dining room has been cleaned and sanitized. The ice packs have been removed from the freezer section of the refrigerators in the 1 East main dining room, the 2 East main dining room and the internet caf; refrigerators.	in M Ig in

Facility ID: 00872

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CENTERS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				FORM /	01/04/2017 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	245293	B. WING			C 11/03/2016		
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - HOPK	KINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343			
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
 observed attached to t clear plastic splash guid of the mixing bowl. The attached to the bowl w and broken and appear assistant dietary mana verified the plastic splay was still being used for asked how long the sp that, the assistant diete "honestly I have not be On 10/31/16, at 2:14 p was completed with the and the DM was asked splash guard on the m this had been reported would be re-ordered. On 11/03/16, at 4:49 p the executive director of had not been aware th however, when it was I she'd asked the DM to and to have it replaced The facility's undated p Equipment directed: "T should be maintained to the residents and assoc Kitchenettes 2 North Main dining roor seal was observed to to hanging loose below th 	ess steel mixing bowl was the machine and a hard ard was in place on the rim e plastic splash guard vas observed to be cracked ared brittle to touch. The ager was interviewed and ash guard was broken but r food preparation. When olash guard had been like eary manager stated, een looking." 0.m. a follow up kitchen tour e dietary manager (DM) d about the broken plastic tixing bowl. The DM stated d and a new splash guard 0.m. during interview with (ED), the ED stated she he splash guard was broken brought to her attention o remove it from the kitchen d. colicy Maintaining Dietary The dietary equipment for the health and safety of poiates" om /16, at 7:28 a.m. the 2 m refrigerator door bottom be stained black and	F 3	871	All food preparation equipment is good repair. All refrigerators in the kitchenettes are maintained at temperatures below 41 degrees. All items have been removed from kitchenette refrigerators upon expira All ice machine spouts and trays are and sanitary. All ice packs are store medication room freezers and not s in kitchenette freezers. All dietary staff have been re-educ on the requirement to have all food preparation equipment in good repa- to immediately notify the dietary ma of any required repairs. All dietary s have also been re-educated on the requirement to log refrigerator temperatures on the kitchenette refrigerators and to immediately rep any temperatures above 41 degrees the dietary manager. The dietary sta have also been re-educated on the requirement to remove all food item the kitchenette refrigerators immedi upon expiration. All housekeeping s have been re-educated on the requirement to properly clean and s the ice machine spouts and trays as schedule. The dietary staff and nurs staff have been re-educated on the requirement to store ice packs in th medication room freezers and not in freezers in the kitchenettes which c food items. Monitoring to ensure compliance of conducted through weekly audits of kitchen food preparation equipment ensure all equipment is in proper we condition. Daily audits will be condu-	I food ation. e clean ed in tored cated air and nager taff oort s to aff us from iately staff s anitize s per sing e n the ontain will be all to orking		

Facility ID: 00872

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245293	B. WING				C)3/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	8:03 a.m. the dietici the refrigerator was were four cartons o thickened juice and also stored in the re On 10/31/16, at 8:2 (NA)-B verified givir and milk from the re giving R21 nectar th and R52 honey thic the refrigerator. 11/02/16, continuou until 8:15 a.m. inclu -7:18 a.m. licensed verified refrigerator 59 degrees Fahrent -7:48 a.m. no one h 7:18 a.m. temperate two cartons of thick white milk and one there are several th three pitchers of juic containers of yogur -7:59 a.m. dietary a refrigerator door an temperature of the degrees when show 40 then asked to ch degrees. -8:03 a.m. cook-A cor efrigerator temperator degrees. Cook-A st	heit. heit. heit. he dietician on 10/31/16, at an verified the temperature in 51 degrees and that there f milk and seven boxes of two boxes of thickened milk efrigerator. 8 a.m. nursing assistant ng R30 nectar thick apple juice efrigerator. NA-B verified hick water and milk, and R56 k apple juice and milk from as observation from 7:18 a.m. ded: practical nurse (LPN)-C temp 15 degrees Celsius or heit. ad entered refrigerator since ure 52 degrees. There were ened milk, two half gallons of half gallon of chocolate milk. ickened fruit juices cartons, ce and several individual	F	371	kitchenette refrigerators to ensure t refrigerators are being maintained temperatures below 41 degrees, co no expired food items and do not h packs stored in the freezer. Weekly will be conducted of all ice machine ensure machine components are c The facility QAPI committee will r the kitchen and refrigerator audits quarterly for further recommendation The date of completion will be 12	at ontain ave ice y audits es to lean. review	

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		AND HUMAN SERVICES				FORM	: 01/04/2017 APPROVED . 0938-0391	
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245293	B. WING	i			03/2016	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - HO	DPKINS	-		725 SECOND AVENUE SOUTH HOPKINS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 371	refrigerator -8:15:45 AM mainter fridge. 2 North Small dinim During initial tour or was an open yogur been open 10/26/10 on 10/31/16, at 8:00 that based on the d have been thrown a 1 West Main dining At 7:02 a.m. on 10/ room refrigerator te be 50 degrees. In the container of potato pitchers of various milk, two nectar app During tour with the a.m. the dietician vertice there is a risk of foot temperature this hig 2 East Main dining During tour with the a.m. the dietician vertice spout was soiled, b potentially unsafe. During observation machine spout was no sign on the mac should not be used During a follow up t	I food items from the enance-A arrived to look at g room n 10/31/16, at 7:33 a.m. there t that was labeled as having 6. During tour with the dietician 8 a.m. the dietician verified late of open, the yogurt should after three days. room 31/16, the 1 West main dining emperature was observed to he refrigerator there was a salad dated 10/24/16, eight juices, one box of nectar thick ple and cranberry juice. e dietician on 10/31/16, at 7:57 erified the refrigerator 2 degrees. The dietician stated od born illness with the gh. room e dietician on 10/31/16, at 8:13 erified the ice machine's ice lack in color and was on 11/02/16, at 7:15 a.m. ice s still soiled black. There was hine to indicate the machine	F	371				

If continuation sheet Page 47 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	black. A sign indica used. During the of Manager wiped som the spout and state bicarb and build up The dietician stated when I noticed it ha notified maintenance it." On 10/31/16, at 8:1 refrigerator temperat degrees and above not maintained in th food borne illness for foods like milk and because of risk for stated food should I yogurt was good for opened. On 10/31/16, at 8:2 check the temperat and juice to give the On 11/2/16, at 1:55 temperature was see increased it to the of handle. I did check During interview on executive director s temperatures to be regulation. ED state responsible for mor notify the dining ser	still observed to be soiled ted the machine should not be bservation, the Dietary ne of the black substance off d, "It is a mixture of lime, of other unknown substance." I, "I put the sign up yesterday d still not been cleaned. I had se on Monday to take care of 4 a.m. the dietician stated the atures should be below 40 freezing. If the temperature is nat range there is high risk of rom temperature sensitive potato salad or thickened juice bacterial growth. Dietician be dated when opened and r three days after being 8 a.m. NA-B said, "I did not ure before I removed the milk	F3	371			

If continuation sheet Page 48 of 56

		AND HUMAN SERVICES			FORM	: 01/04/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY IPLETED
		245293	B. WING			C / 03/2016
NAME OF	PROVIDER OR SUPPLIER	I	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CC		
GOLDEN	I LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371 F 431 SS=D	issues are correcte informed on Monda with refrigerator ten issues to continue. expect that to be fix service." During interview on dietician said she n about the warm refr removed the food of Wednesday for the The facility's Storag dated 2011, directe Department to stora degrees F [Fahrenh manner as to preve according to the po state and local regu 483.60(b), (d), (e) I LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat reconciled. Drugs and biologica labeled in accordar professional princip appropriate access	then we talk about how those d." ED further stated "I was ay that there were some issues nps. I would not expect the If there is an issue I would ked timely so we can continue 11/3/16, at 12:41 p.m. the otified maintenance Monday rigerator temperatures and on Monday and again on refrigerator on 2 North. ge of Refrigerated Foods policy d the Dining Services e refrigerated food at 41 neit] or below and in such ent spoilage and contamination licy guidelines and federal ulations. DRUG RECORDS, SUGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted bles, and include the	F 3			12/13/16

Facility ID: 00872

If continuation sheet Page 49 of 56

	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			PLETED	
		245293	B. WING			C 11/0) 3/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE	
F 431	Continued From pa	ae 49	F 4	121				
1 101	applicable.	90 -0	1 4	101				
	In accordance with	State and Faderal lowe the						
	facility must store a	State and Federal laws, the II drugs and biologicals in						
	locked compartments under proper temperature controls, and permit only authorized personnel to							
	have access to the							
	The facility must pro	ovide separately locked,						
		compartments for storage of ed in Schedule II of the						
	Comprehensive Dru	ug Abuse Prevention and						
		and other drugs subject to n the facility uses single unit						
	package drug distril	bution systems in which the						
	quantity stored is m be readily detected.	inimal and a missing dose can						
		. <u>.</u>						
	This REQUIREMEN	NT is not met as evidenced						
	Based on observat	ion, interview and document			The tuberculin vials currently in use			
		ailed to ensure medications estored and disposed of			facility are properly dated when ope and disposed of properly when expl			
	properly in 3 of 3 m	edication rooms, and one			All medications requiring disposal a			
		iewed for medication storage.			disposed properly. All multi-dose medications are pro			
	Findings include:				dated when opened and are dispos in accordance with expiration dates			
		tion room had four open vials			medications are disposed in the pro			
		dication to skin test for and stored for use. One vial			manner. All licensed nurses have been			
	had an unreadable	date when opened. Three			re-educated on the requirement to a			
		undated. It was unclear why vials of Tuberculin open at the			multi-dose medications when they a opened and dispose of medications			
	same time.	'			accordance with expiration dates. A	All		
	The 1 East medicat	tion refrigerator had an expired			licensed nurses have been re-educ on the proper methods to dispose of			

Facility ID: 00872

If continuation sheet Page 50 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/04/201 APPROVE 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COM	E SURVEY PLETED
		245293	B. WING		C 11/03/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDE	N LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 431	vial of tuberculin that expiration of 10/27/ seven days before) The 2 East medicati tuberculin that was The facility Policy for Facility,Storage of M 3 or 3, date written Section E, "When the manufacturer's com the container or via 1) "The nurse s sticker on the medic opened and the [net the best sticker to a opened" and "expiration date of the days unless the mat another date or reg differenent dating (s WITH SHORTENE facility failed to follo multi-dose medication (LPN)-B was obsert to R33. R33 was ob medications, then s floor approximately then picked up the p returned to the medic (without performing matched the pill rett Vitamin D, and pou she picked up a wh paused and looked surveyor asked LPN	at was open and dated 16 (the medication expired ion refrigerator had one vial of open but undated. or Medication Storage in the Medications (section 4.1, page 5/12) read: ne original seal of a tainer or vial is initially broken, I will be dated. hall place a [Date Opened] cation and enter the date w date of expiration] (NOTE: offix contain both a "Date ation" notation line). The ne vial or container will be [30] nufacturer recommend ulations/guidelines require see 11.21- MEDICATIONS D EXPIRATION DATES)." The w their policy on dating	F 43	1 non-narcotic medications in the medication receptacles in the me rooms. Monitoring to ensure complian conducted through weekly medic audits to ensure that multi-dose medications are properly dated w opened and disposed of when e. The facility QAPI committee wi the medication audits quarterly for recommendations. The date of completion will be	ce will be cation vhen xpired. ill review or further	

If continuation sheet Page 51 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245293	B. WING				C 03/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 F 458 SS=C	then scooped up the the spoon and put to on the medication of On 11/3/16, at 2:23 should not have put they were going to be also verified that me into the garbage, bu medication disposa medication room. He check with the direct before giving the fir would only dispose medication room dis spit it onto the floor -At 2:37 p.m. RN-A "technically it should orange bin, in the me verified there was of disposal bin in each The Equipment and Medications policy of following equipeme acquired and maint proper storage, pre medication adminis 483.70(d)(1)(ii) BED LEAST 80 SQ FT/F Bedrooms must me per resident in mult	e three round white pills with hem into the trash receptacle eart. p.m. RN-A stated LPN-B t medications into her hand, if be given to a patient. RN-A edications should not be put ut should have gone into I (medication waste bin) in the lowever RN-A felt she should etor of nursing services (DNS) hal answer. LPN-B stated "I of medication in the sposal bin, if the patient had ". stated the DNS verified, d be [disposed of] in the hedication room." RN-A one orange medication in medication room. I Supplies for Administering revised 2014, indicated the nt and supplies should be ained by the facility for the paration, and administration of ner for medications, sharps, vaste generated during tration. DROOMS MEASURE AT	F 4				12/13/16

Facility ID: 00872

If continuation sheet Page 52 of 56

		AND HUMAN SERVICES			FORM	: 01/04/2017 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	` ´CO№	E SURVEY IPLETED C
		245293	B. WING _			03/2016
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	• •	
GOLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 458	Continued From pa	ge 52	F 4	58		
	by: Based on observat did not provide 80 s rooms 141, 142, 14 258, 260, 264, 269, Findings include: During the survey of the 14 rooms with r delivery of care. Du through 11/3/16, no to size of room how concerns with the s facility was notified room. During the er 10/31/16, at 8:20 a. stated she would pr	NT is not met as evidenced tion and interview, the facility square feet per resident for 43, 144, 146, 165, 171, 240, 271, and 277. cares were observed in four of the concerns were noted in the tring the survey from 10/31/16, 6 families had concerns related vever, R11 in room 277 had size of the room and when R11 was moved to a different ntrance conference on .m. the executive director rovide a letter to request the was provided the same day.		Golden Living Center Hopkins w to request a waiver under F458 i to resident room size. The specif to be included in this waiver are: 146, 240, 258, 260, 264, 269, 27 The following rooms previously in for the waiver have been private 141, 143, 165, 171. These rooms were constructed and do not meet the current requ for square footage in two bedroo There is no method available to it the size of the rooms without cau hardship on the facility. Granting this waiver would not affect the residents in the aforem rooms. The resident's health, tre comfort, safety and well-being wi maintained at the highest possib Currently there are no concerns complaints from residents regard room size. The Executive Director is respo for the correction and monitoring prevent a reoccurrence of the de	n regards ic rooms 142, 144, 1, 277. dentified rooms: l in 1955 irements ms. ncrease using aversely entioned atments, Il be le level. or ling their onsible to	
F 465 SS=E	483.70(h) SAFE/FUNCTIONA E ENVIRON	AL/SANITARY/COMFORTABL	F 46		-	12/13/16
		ovide a safe, functional, ortable environment for the public.				
	This REQUIREMEN	NT is not met as evidenced				

Facility ID: 00872

If continuation sheet Page 53 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245293	B. WING			11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	review, the facility fa functional, sanitary which included 17 r (201, 202, 203, 204 222, 243, 254, 259, shared bathrooms w Findings include: During the environm p.m. with the execu- maintenence direct employee (M-A), the (H-M) and executive ED-B) the following and confirmed by th -Room 201- The ba- jagged edges and s along the sink was floor was sticky with -Room 202-The floor porcelein in the toile -Room 203-A large back of the room do	ion, interview and document ailed to ensure a safe, and comfortable environment ooms and on the second floor , 205, 207, 210, 211, 220, 260, 261, 262, 277) and the within these rooms. nental tour on 11/3/16, at 1:25 tive director (ED), or (M-D), maintenance e housekeeping manager e director interns (ED-A and observations were identified ne ED and M-D: athroom door frame had scrapes along the door, plaster exposed and the bathroom n urine. or was sticky with urine, the et was scratched. gouge was observed on the	F 4	65	All door frames identified as scratc gouged have been repaired. All are identified as requiring plaster repair been repaired. All bathroom floors identified as requiring additional cle have been stripped and cleaned. T replacement vendor has been cont in order to schedule a time to repla flooring that needs to be replaced. toilets identified as requiring repair been repaired. For all doors identifi gouges the facility has contacted a to provide the facility with the neces materials to repair the doors. Mater have been placed on order as of 12 Furniture identified as ripped has be removed from use. Wheelchair cus and footrests identified have been reassessed and the materials for correction have been ordered. All door frames will be free of scra and gouges. Wall plaster is in good in resident rooms and bathrooms. A bathroom floors are clean and vinyl replaced by floor replacement venc toilets are clean and in functional of All doors will be in good repair upor reception of materials needed to re the doors. All furniture in resident ro	as have have eaning he floor acted ce the All have ed with vendor ssary rials 2/6/16. een thions atches repair All will be lor. All rder. n pair poms	
	the egdes. -Room 205- The ba gouges and the linit was peeling off. Th	throom door had deep ng on the back of the toilet le bathroom had a urine odor. throom smelled of urine, the			fabric. All wheelchair cushions and rests have been assessed for need repairs and materials have been or The maintenance staff have beer re-educated on the requirement to doors and door frames free of scra and gouges, plaster in good repair,	foot led dered. n keep tches	
		ing up and there was a used			flooring in bathrooms in good repai		

Facility ID: 00872

If continuation sheet Page 54 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245293	B. WING			C 11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	urinal sitting on the -Room 210- There of the bed room dou The floor was stain chair in the room we exposed. -Room 211- Plaster along the back of th and the doors in the -Room 220 The roo urine odor, the bath scratched areas an around the edges of -Room 222-There we bathroom door and on the toilet. The we plaster by the head The room smelled of -Room 243- The toil the bathroom. -Room 254-The lind bathroom and confi a trip hazard. -Room 262-The wh cracked and cushio wheelchair cushion -Room 262-The floo and there was a str	bstance on the sides of the back of the toilet. were gouges out of the back or and at the top of the door ed in the bathroom. A facility as ripped and the cushion was "was exposed coming up he wall and edge of the toilet e bathroom were scraped. or and bathroom had a strong room door had several d there was black staining f the toilet. were large gouges in the the porcelain had worn away vall was scraped, exposing of the bed in the bedroom. of body odor. ilet cover did not fit the toilet in bleum was coming up in the rmed by the Administrator as eelchair cushions were on was exposed on the and foot rests. or was sticky in the bathroom ong urine odor.	F 4	65	toilets in functional order, furniture f from ripped fabric and wheelchair cushions and parts in good repair. A housekeeping staff have been re-educated on the requirement to k all bathroom floors clean and odor f Monitoring to ensure compliance conducted through weekly environm audits checking door frames, doors plaster, bathroom floor sanitation ar repair, furniture repair and wheelcha cushions and parts for good repair. The facility QAPI committee will re the environmental audits quarterly further recommendations. The date of completion will be 12-	All ree will be nental , room nd air eview or	
	-Room 277- The ba	throom smelled of urine and					

		AND HUMAN SERVICES				FORM	01/04/2017 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:				COM	PLETED
		245293	B. WING			C 11/03/2016	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	11/	55/2010
GOLDEN	LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH		
		TEMENT OF DEFICIENCIES	10	-	IOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION	.1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE				(X5) COMPLETION DATE
F 465	Continued From no	90 EE					
1 403	Continued From pa	on the bathroom wall	F 4	65			
	exposing plaster.						

Facility ID: 00872

F6293025 APPROVED Then & Sull TED: 11/30/2016

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		246293	B. WING		11/01/2015
	ROVIDER OR SUPPLIER	AND		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH	
JOLDEN	LIVINGCENTER - NUFRI	n3		HOPKINS, MN 85343	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD(TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO SE COMPLET
K 000	INITIAL COMMENTS		ĸœ	00	
	FIRE SAFETY			K 000	
		C WILL SERVE AS YOUR		Submission of this Response	and Plan
	ALLEGATION OF CO	MPLIANCE UPON THE		of correction is not a legal a that a deficiency exists or	that this
		BOTTOM OF THE FIRST		Statement of Deficiency was	correctly
		2567 FORM WILL BE		cited, and is also not to be con	strued as
		TION OF COMPLIANCE		an admission of fault by the fa Executive Director or any er	cility, the
	UPON RECEIPT OF	AN ACCEPTABLE POC, AN		agents or other individuals wh	n draft or
		YOUR FACILITY MAY BE		may be discussed in the Resp	onse and
	CONDUCTED TO VA			Plan of Correction. In	addition,
	SUBSTANTIAL COM			preparation and submission of	
	REGULATIONS HAS	BEEN ATTAINED IN TYOUR VERIFICATION		of Correction does not con	stitute an
	ACCORDANCE WITH	TOUR VERIFICATION.		admission or agreement of an	y kind by
	A Life Safety Code Su	irvey was conducted by the		the facility of the truth of	any facts
	Minnesota Departmen	nt of Public Safety, Fire		alleged or the correctness	of any
		lovember 01, 2015. At the		conclusions set forth in the alle	gations.
	time of this survey, Go	olden LivingCenter Hopkins			
		tantial compliance with the		Accordingly, the Facility has	prepared
	requirements for partic			and submitted this Plan of (Correction
	Medicare/Medicaid at			prior to the resolution of a	ny appeal
	483.70(a), Lite Safety	from Fire, and the 2012 e Protection Association		which may be filed solely b	ecause of
		e Protection Association		the requirements under state a	nd federal
	Chapter 19 Existing H	lealth Care RECEIV	ED	law that mandate submission of Correction within ten (10) of	of a Plan
	PLEASE RETURN TH			survey as a condition to par	ticipate in
	CORRECTION FOR 1	THE FIRE SAFETY		Title 18 and Title 19 progra	ms. This
	DEFICIENCIES (K-TA		16	Plan of correction is submitt facility's credible allege	ed as the
	Health Care Fire Inspe	ections		compliance.	
	State Fire Marshal Div	vision MN DEPT. OF PUBLIC		Comprise .	
		Suite BISATE FIRE MARSHAL			
	St. Paul, MN 55101-51	145, or			
RATORYO	HARCTORY ORPROVIDERS	UPPLIER REPRESENTATIVE'S SIGNATURE		IT CO. TITLE	(XB) DATE ,
IIX/	211 NHHANN	ALA		Executive Director	12/51

other saleguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

FORM CMS-2567(02-09) Previous Versions Obsciele

Facility ID: 00672

		ND HUMAN SERVICES				FOR	D: 11/30/201 MAPPROVE
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CNSTRUCTION MAIN BUILDING 01		E SURVEY PLETED
		245293	B. WING			11	/01/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		0112010
GOLDEN	LIVINGCENTER - HOPK	N5			SECOND AVENUE SOUTH PKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefi Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ĐÉ	(LS) COMPLETION DATE
K 000	Continued From page	e 1	к	000			
	By E-Mail to: Marian.Whitney@sta Angela.Kappenman@	te.mn.us and					
	THE PLAN OF CORP	RECTION FOR EACH					
	1. A description of win to correct the deficier	at has been, or will be, done xy.					
	2. The actual, or prop	osad, completion date.					
	3. The name and/or ti	itle of the person					
		tion and monitoring to					
	The original building	was built in 1958, is					
	two-stories, has no be sprinkler protected an						
		built in 1960, is two-stories, fully fire sprinkler protected					
		construction; built in 1965, is two-stories, fully fire sprinkler protected					
	and is of Type II(222)						
	has no basement, is f and is of Type II(222)	ully fire sprinkler protected construction;					
		built in 1993, is two-stories, Illy fire sprinkler protected construction;					
	detection in the corrid corridors which is more department notification	alarm system with smoke ors and spaces open to hilored for automatic fire n. The facility has a and had a census of 106 at					

Event ID- KKYX21

Facility ID 00072

If continuation sheet Page 2 of 5

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES		FC	TED: 11/30/20 DRM APPROV NO: 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY IMPLETED
		246293	8. WING		11/01/2016
NAME OF P	ROMDER OR SUPPLIER		डा	REET ADDRESS, CITY, STATE, ZIP CODE	10002010
	LIVINGCENTER - HOPK	1418	72	SECOND AVENUE SOUTH	
GOLDEN	LIVINGCEN IER - NOFK		н	OPKINS, MN 66343	
(X4) ID PREFIX TAG	EACH DEFICIENC	IATEMENT OF DEFICIENCIES 2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(25) COMPLETIN DATE
K 000	Continued From pag	e 2	K 000		
	the time of the survey	у.	1	К 352	
K 252	NOT MET as eviden	2 CFR, Subpart 483.70(a) is ced by: System - Supervisory Signals	14 0 5 7	The facility will contact the company that provides service to the fir	e
5S=F	Sprinkler System - S		K 352	sprinkler system to ensure that the annunciator panel is ordered to b	e
	Automatic sprinkler s			installed in a location that is monitore	
	attachments are insta	alted and monitored for		by staff continuously throughout al	U
		e with NFPA 72, National		three shifts.	
		ling Code, and provide a	1		
	signal that sounds an	d location or approved		The Californ manufactor has a	_
	remote facility when			The facility currently bas an annunciator panel at the front entrance	
	impaired.	aprinder operation ta	Q.	of the building that is in working orde	
	9.7.2.1, NFPA 72			and will continue to have the panel in	
		not met as evidenced by:		use in addition to the new panel that	
		and staff Interview, the		will be installed in the new location.	**
		automatic sprinkler system			
		ents in accordance with re Alarm and Signaling		Staff will be re-educated to ensure that	at .
		yed at a continuously		they understand the use of the curren	it
		approved remote facility		annunciator panel when the fire alarm	n
		tion is impaired. NFPA 72,		system is activated.	
		t practice could affect all 108			
	residents.			The Director of Maintenance wil	
	Sindiana Instuder			ensure that the annunciator panel i	
	Findings Include:			installed and in proper working orde	
	On a facility tour betw	reen the hours of 1100 and		and will monitor through random	n
	1500 on November 0			audits.	
	revealed that the facil	ity does not have a remote			n
		r panel installed in a area		The facility QAPI committee will review the audits for furthe	
	that is continuously se	upervised by staff.		review the audits for furthe recommendations.	1
				Date completed by: 12/13/16	
	This deficient practice	wat verified by the		San completed by, 12/15/10	
	the annear highligh	I THE TELLED BY UR			

÷.

Event (D; KKV2(2)

Facility ID: 00872

If continuation sheet Page 3 of 5

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SLIPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 11 - MAIN BUILDING 01	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		245293	B. WING		11/01/2016
VAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, 2P CODE	
GOLDEN	LIVINGCENTER - HOPKI	NS		28 SECOND AVENUE SOUTH IOPKINS, MN 65343	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ið Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
K 352	Continued From page	3	K 352		
	Maintenance Director	at the time of inspection.			
K 712	NFPA 101 Fire Drills		K 7 12		
SS=C				K 712	
	Fire Drills			/	
	signal and simulation conditions. Fire drills a times under varying ci on each shift. The sta and is aware that drills routine. Responsibility conducting drills is as persons who are quali Where drills are condu 6:00 AM, a coded and instead of audible alar 18.7.1.4 through 18.7. 19.7.1.7 This STANDARD is n Based on documenta interview, the facility ci documentation that fin once per shift per quali varying times and con-	are held at unexpected onditions, at least quarterly if is familiar with procedures are part of established for planning and signed only to competent lifed to exercise leadership. ucted between 9:00 PM and ouncement may be used ms. 1.7, 19.7.1.4 through of met as evidenced by: tion review and staff ould not provide a drills were conducted rer for all staff under ditions as required by 2012 .7.1.4. through 19.7.1.7.		Fire drills will be conducted on and third shift and properly doe in order to ensure that documentation is reflected. The maintenance staff has educated to ensure that all fire documented appropriately. Monitoring to ensure complia be conducted by the Main Director or designee through a ensure that that documentation fire drills are in place. The facility QAPI committe review the audits for recommendations. Date completed by: 12/13/16	accurate accurate s been drills are nce will ntenance audits to n of the
	Findings include:				
1	1500 on November 01, revealed that the facilit	y could not provide pleting a fire drill for the			

Event ID: KKYX21

Facility ID 00872

If continuation sheet Page 4 of 5
TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	TRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		246283	B. WING		n. — Anazátá Al A C		
NAME OF P		645665	B. VWING		ADDRESS, CITY, STATE, ZIP CODE	11/01/2016	
GOLDEN	LIVINGCENTER - HOPKI	NS		726 SEC	H SECOND AVENUE SOUTH OPKINS, NN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
K 712	Continued From page This deficient practice Administrator at the ti	was verified by the	K	712			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted November 30, 2016

Ms. Talia Aramalay, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, MN 55343

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5293027 and Complaint Numbers H5293055 and H5293058.

Dear Ms. Aramalay:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5293055 and H5293058. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Golden LivingCenter - Hopkins November 30, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us Golden LivingCenter - Hopkins November 30, 2016 Page 3 Golden LivingCenter - Hopkins November 30, 2016 Page 4

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00872	B. WING		C 11/0	; 3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE 5, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	the State Licensing federal software. Ta assigned to Minnes nursing homes. The appears in the far le Tag." The state stat	TS: nent of Health is documenting Correction Orders using the ag numbers have been tota state statutes/rules for e assigned tag number eft column entitled "ID Prefix sute/rule number and the				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/09/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 54

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00872	B. WING		11/	03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO		COND AVENUE IS, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	corresponding text compliance is listed of Deficiencies" col Comply" portion of column also include violation of the state "This Rule is not m the surveyors findir of Correction and th During the recertific through 11/3/16, co conducted at the tir An investigation of completed. The con Deficiency(ies) issu	of the state statute/rule out of d in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidenced by." Following ngs are the Suggested Method ne Time Period for Correction cation survey on 10/31/16, implaint investigation(s) were ne of the standard survey. complaint, H5293055 was mplaint was substantiated. ied at 0265 and 1810. substanitated. Deficiency(ies	9 d			
2 265	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT MN Rule 4658.008 Resident Health St A nursing home mu policies to guide sta physicians, physicia	IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. 5 Notification of Chg in	2 265			12/13/16

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00872	B. WING			03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 265	legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica A. an accident results in injury and physician interventi B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinica C. a need to al example, a need to of treatment due to begin a new form o D. a decision t resident from the ne E. expected an This MN Requirement by: Based on interview facility failed to ensi- representative was changed and change	e or an interested family ent's acute illness, serious At a minimum, the director of nd the medical director or an must be involved in the se policies. The policies must address at least the tion times for: involving the resident which has the potential for requiring on; change in the resident's r psychosocial status, for ation in health, mental, or a in either life-threatening al complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment; o transfer or discharge the ursing home; or d unexpected resident deaths ent is not met as evidenced and document review, the		Corrected	, ,	

Minnesota Department of Health STATE FORM

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If continuation sheet 3 of 54

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00872	B. WING			03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	ILIVINGCENTER - HO)PKINS	COND AVENUE NS, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	ge 3	2 265			
	without behavioral of acute kidney failure	ncluded unspecified dementi disturbance, hypothyroidism, and repeated falls obtained Record dated 4/26/16.	a			
	note dated 1/27/16 edema (swelling) o redness on the righ been started on a r	e interdisciplinary team (IDT) it was revealed resident had n both lower extremities, som t inner thigh and resident had new order for Lasix 20 nouth every morning for three	l ne d			
	progress notes date was revealed the m documentation the	e interdisciplinary team (IDT) ed 1/7/16, through 1/29/16, it redical record lacked wife or legal representative f the change in condition and ent plan.				
	resident had a diag dementia, due to co decision making ca	ated 1/11/16, indicated nosis of Alzheimer's or relate ognitive loss, had diminished pabilities and as a result the secured Alzheimer's Care				
	Assessment (CAA)	ss/dementia Care Area dated 1/20/16, indicated ntia and had a supportive				
	(LPN)-C verified real Lasix on 1/26/16, h lacked documentat representative had	a.m. licensed practical nurse sident had been started on owever the medical record ion the wife or the legal not been notified of the and the change in condition.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	On 11/3/16, at 7:35 services (DNS) sta the staff nurse to d been notified of any included the medic medical record lack legal representative change in condition On 11/3/16, at 7:50 conversation a fam not pleased with th R191 was in the fac during one visit to t were swollen like a Lasix. I was never changes." Family n R191's legal represent be told. The facility Notifical Health Status polic "The center will corn nurse practitioner of known notify the re an interested family (A) An accident wh potential for requirin Notification: Within assessment has be be a potential for pl (B) Acute illness or resident's physical, (i.e. deterioration in	 a.m. the director of nursing ted she would have expected ocument resident family had y changes in treatment which ations. DNS verified the ked documentation the wife or e had been notified of the n and treatment plan. D a.m. via a telephone indicated they were e care during the brief time cility. Family member indicated he facility had noticed "his feet balloon. I think he needed notified of any medication nember indicated she was sentative and was supposed to to y dated 10/12/16, directed nsult the resident's physician, or physician assistant, and if sident's legal representative or y member when there is: ich results in injury and has the ng physician intervention. 24 hours from the time as een made indicating there may hysician intervention. 				

STATE FORM

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING			C D 3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS	OND AVENUE S 5, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ige 5	2 265			
		e an existing form of treatment sequences, or to commence a ent)"				
	Minnesota Residen 1,2007, provided to representative direc Your Condition. The	The Combined Federal and ts Bill of Rights dated July resident and legal cted "14. Notice of Changes in a facility must consult with you there is an accident involving.				
	The Director of Nur develop policies an resident's represen changes in conditio treatments. The DC all appropriate staff	THOD OF CORRECTION: rsing (DON) or designee could d procedures to ensure each tative is promptly notified of all in and/or changes in DN or designee could educate on the policies/procedures, ure ongoing compliance.				
	TIME PERIOD FOF (21) Days.	R CORRECTION: Twenty One				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/13/16
		omprehensive plan of care I personnel involved in the t.				
Ainan	by: Based on observati review, the facility fa care was implement	ent is not met as evidenced ion, interview and document ailed to ensure the plan of ited for shaving for 1 of 3 iewed for activities of daily		Corrected		

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	ILIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565		age 6 d to assist 1 of 2 residents	2 565			
	(R52) to the toilet in toileting plan, and related skin break repositioning and s	n accordance with their failed to prevent non-pressure down related to lack of shearing for 1 of 4 residents wheelchair positioning.				
	Findings Include:					
	have black facial h mouth. On 11/1/16	on 10/31/16 at 1:42 p.m., to air on the right edge of her , at 12:23 p.m. the black facial ne right side of R28's mouth.				
	was observed to as changed R28's inc assisted R28 to ge comb the resident's table in the small d that time, R28 was	a.m. nursing assistant (NA)-C ssist R28 with adl's. NA-C ontinence product, then t dressed, wash face and s hair. NA-C then took R28 to a ining room for breakfast. At observed to have eight black on the right side of her mouth.	a			
	provide person hyg for R28. The NA di	5 a.m. NA-C was obsesrved to giene care, incontinence care d not identify or assist R28 with ck 1/2 inch hairs on the right	n			
	R28's care plan ide assist R28 with per	entified interventions for staff to rsonal hygiene.				
	R28 was asked ab	n 11/3/16, at 7:21 a.m. when out facial hair, R28 replied, "A facial hair. Do I have facial				
	said, "She accepts	n 11/3/16, at 9:58 a.m. NA-C and appreciates help. I did no was so busy. She has a little	t			

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		00872	B. WING		11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	mustache. I normally shave her after one to two days depending on the beard. We are to look every morning when she gets up and shave her if needed. I should have done so today."					
	dining room reading slouched part way knees above the to at approximately 45 higher than hips. R Additional observat -7:30 a.m. the direc walked through the other residents. -7:32 a.m. nursing clothing protector. I wheelchair position -7:44 a.m. registers Care hospice took -7:55 a.m. RN-K re table and gave R52 remained higher th -8:14 a.m. R52 put dining room table.	ed nurse (RN)-K with Asera R52 out of the dining room. turned R52 to the dining room 2 a magazine. R52's knees an the table top. shed himself-back from the				
	adjust his feet. -8:24 a.m. Breakfa R52. NA-A adjusted were not above the -9:03 a.m. licensed wheeled R52 to the	hecked R52's foot rest and ast meal was placed in front of d R52's chair so R52's knees table top. practical nurse (LPN)-D s small dining room and table. R52 was positioned				
	upright at the table left the table top. - 9:05 a.m. R51. RI way without telling him. R52's eyes we	with both knees lying to the N-D reclined Broda chair part R52 she was going to recline ent wide open and R52 opened I upper body stiffened. RN-D				

Minnesota Department of Health STATE FORM

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY PLETED
		00872	B. WING		C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE	
		725 S	ECOND AVENUE	SOUTH	
GOLDEN	I LIVINGCENTER - HO	OPKINS	KINS, MN 55343		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	COMPLET DATE
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENC	DATE
0.505		<u>^</u>	0.505		
2 565	Continued From pa	ige 8	2 565		
	-9:54 a.m. R52 was	s sitting in Broda chair at tal	ble		
	playing cards by his	s self. R52 was sliding part			
		The Broda chair was in an			
	upright position.				
		ting in chair playing cards.			
	0	d with R52 slouched down i	n		
	the chair.				
		es assistant-A moved R52 to	0		
	strap of the parachu	p and had R52 hold on to			
		was interviewed as to how			
	frequently R52 was				
		the Broda chair. LPN-C sai	d		
		d and changed every two	G ,		
		ask the nursing assistants			
	when he was last c				
	- 11:23 a.m. LPN-C	said, "[NA-B] is at lunch. I	am		
		ne right now since I assume			
		done. They should have dor	ne it		
	after breakfast."				
		rought R52 to room and lef	t		
	room to locate a lift				
	to observe cares.	or obtained R52's permissic)[]		
		eturned and said needed to			
	wait for a lift as the				
		entered room and obtained			
	permission to obse				
		nd NA-B entered with			
	mechanical lift.				
		nd NA-B left to get EZ stan	d		
		an EZ stand transfer.			
		nd NA-B washed hands and			
		A explained to R54 what the			
		Ind NA-B put on EZ stand b	Deit		
		standing position and took	20		
		om. NA-B pulled down R52 I the soiled incontinent brief			
		pad was very wet with uring			
		puu wuu voiy wol willi Ulli	u. I		1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00872	D. WING		11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDEN	I LIVINGCENTER - HO		OND AVENUE S, MN 55343	SOUTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ige 9	2 565			
	allow R52 privacy. - 11:48 a.m. NA-B s sliding down in the since before breakf two hours. -11:49 a.m. LPN-C he was standing in area noted on scrot NA-B to put R52 in assess and measu At 11:57 a.m. RN-D R52's scrotum and (cm.) long by x 0.5 was too shallow to said that was a new to call it a Stage two (Partial-thickness lo dermis. The wound moist, and may also ruptured serum-fille and R52 sliding in t R52's OT-Therapis Summary dated 7/2 caregiver education	D measured the wound on stated it was 1.5 centimeters cm. wide. RN-D said the depth measure. RN-D and LPN-C v wound and they were going o pressure ulcer bas of skin with exposed I bed is viable, pink or red, o present as an intact or ed blister) due to prolong sitting	3			
	hips in wch every 1 unable to initiate se impairment and rec	-2 hours due to pt [patient] condary to cognitive commendation for leisure it of pt on tables to reduce				
	Swallow study care staff to ensure prop self-care deficit car 9/21/16, to toilet R5	Difficulty as related to Abnorma plan dated 10/6/15, instructed per positioning at meals. R52's e plan instructed staff on 52 every two hours. During the eration in skin integrity related	1			

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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	risk for scrotum she R52's significant ch Data Set (MDS) dat both short and long diagnoses of deme (loss of movement failure to thrive. R52 required assistance transfers and bed n incontinent of bowe identified R52 was skin was intact. The Treatment Adm 11/1/16 through 11// be repositioned eve The date of the ord During an interview said, "We reassess assistant director of wound is caused by pressure ulcer. The cream, off loading/r ordered a low air los shearing was cause with the EZ stand." considered the slidi knees as possible of	ange of scrotal edema and at earing care plan were initiated. ange of condition Minimum ted 9/6/16, indicated R52 had term memory problems and ntia, osteoarthritis, hemiplegia on one side of the body) and 2's MDS indicated R52 with dressing toileting, nobility and was always I and bladder. R52's MDS at risk for skin breakdown and hinistration Record dated 30/16, indicated R52 was to rry two hours and as needed. er was 4/9/15. 11/2/16, at 2:03 p.m. LPN-C ed the wound with the inursing (ADNS) and the v shearing and is not a treatment will be barrier eposition every hour. I have ss mattress. We believe the ed when they transferred [R52] LPN-C said "We did ng in the Broda chair and high causes of shearing and have have their Physical Therapist		DEFICIENC	21)	
	said, "[R52] tries to in pain or is wet. If h	11/3/16, at 10:04 a.m. NA-A move sometimes when he is he was at the table with his ble we should have sat him up m up in the chair."				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF	AME OF PROVIDER OR SUPPLIER STREET			TATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HO)PKINS	OND AVENUE S, MN 55343	SOUTH		
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2 565	During interview wit at 11:39 a.m. DNS NA-B had admitted when he should hav was not deliberate I Office of Health Fac suspended NA-B un investigation, becau neglect under the v said, "I went and re educator and LPN after lunch. The RN determined it looke traumatic injury. R5 and his scrotum is of The ADNS said, "H and then standing v it was such frank bl the transfer." The D is not wound certific educator. The DNS ensure residents we and would not be sl their wheelchairs. T expected staff to er upright while eating During interview on said, "R52 sits forw he is trying to pull h During interview on occupational therap usually provided the stated therapy had positioning. "We rear	th DNS and ADNS on 11/3/16, said they met with NA-B and he had missed checking R52 ve. The DNS said, "He felt it but I did report it to OHFC (the cility Complaints) and ntil we complete the use it could be construed as ulnerable adult act. The ADNS assessed with our RN clinical C. We reassessed R52 right I clinical educator and I d more like a shearing 2 is in a reclining wheel chair quite edematous and large." e slid down during the transfer with the standing lift. Because ood we feel it occurred during DNS also confirmed the ADNS ed nor is the RN clinical stated she expected staff to puld be positioned properly liding repeatedly or leaning in The DNS further stated she nsure residents were sitting 11/3/16, at 1:29 p.m. LPN-D ard a lot. He almost looks like				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE 5, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	The director of nurs to follow care plans cares and services to audit and monito TIME PERIOD FOI	THOD OF CORRECTION: sing could re-educate all staff s in regards to specific resident , and could develop a system or for compliance. R CORRECTION: Twenty-one				
2 830	(21) days. MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and	2 830			12/13/1
	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident				
	by: Based on observat review, the facility f (R56, R52, R21, R evaluated for whee reviewed for positio	ent is not met as evidenced ion, interview and document failed to ensure 4 of 4 residents 100) were appropriately lichair positioning needs oning. In addition, the facility of 4 residents (R52) maintained		Corrected		
	Findings include:					

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If continuation sheet 13 of 54

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOLITH	STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
725 SECOND AVENUE SOUTH HOPKINS, MN 55333 Image: Colspan="2">Provider: Propriotice: Colspan="2">Provider: PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEIDED BY FULL FREGULATORY OF LSC IDENTIFYING INFORMATION) Ip Precent TAG Provider: PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEIDED BY FULL FREGULATORY OF LSC IDENTIFYING INFORMATION) Ip Precent TAG Provider: PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEIDED BY FULL FREGULATORY OF LSC IDENTIFYING INFORMATION) Ip Precent TAG Provider: PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEIDED BY FULL TAG 2 830 Continued From page 13 2 830 2 830 EAGES: REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 13 2 830 2 830 EAGES: REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 13 2 830 EAGES: REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY 2 830 Continued From the Admission Record dated 11/3/16. R56's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated resident had both short and long term memory problems, had functional limitation of range motion to both lower extremities and used a wheelchair indicated R56 was at risk for thysical functioning deficit related to cognitive impairment related to secondary vascular dementia. The care plan indicated resident used a wheelchair and staff was to keep the wheelchair in a reclined position until food was served at all meals. Care plan however, did not address the wheelchair, R56's		00872				11/0	03/2016
GOLDEN LIVINGCENTER - HOPKINS HOPKINS, MN 55343 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG IP POVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 2 830 Continued From page 13 2 830 2 830 R56's diagnoses included vascular dementia, major depressive disorder, hemiplegia and hemiparesis obtained from the Admission Record dated 11/3/16. 2 830 R56's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated resident had both short and long term memory problems, had functional limitation of range motion to both lower extremities and used a wheelchair for mobility. Activities of daily living Care Area Assessment (CAA) dated 12/15/15, indicated R56 needed total assistance for transfers and locomotion due to dementia, impairment related to secondary vascular dementia. The care plan indicated resident used a wheelchair and staff was to keep the wheelchair in a reclined position until food was served at all meals. Care plan however, did not address the wheelchair no staff was to keep the wheelchair in a reclined position ing. No 111/2/16, at 7:20 a.m. R56 was observed in the large dining room slouched part way down in high back til in space wheelchair. R56's body angled from left to right with legs dangled to right side off wheelchair. -At 7:30 a.m. the director of nursing services (DNS) walked through	NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 13 2 830 R56's diagnoses included vascular dementia, major depressive disorder, hemiplegia and hemiparesis obtained from the Admission Record dated 11/3/16. 2 830 R56's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated resident had both short and long term memory problems, had functional limitation of range motion to both lower extremities and used a wheelchair for mobility. Activities of daily living Care Area Assessment (CAA) dated 12/15/15, indicated R56 needed total assistance for transfers and locomotion due to dementia, impaired balance and history of cerebrovascular accident (CVA) with mobility deficits. Care plan dated 8/13/16, indicated R56 was at risk for physical functioning deficit related to cognitive impairment related to secondary vascular dementia. The care plan indicated resident used a wheelchair and staff was to keep the wheelchair in a reclined position until food was served at all meals. Care plan however, did not address the wheelchair positioning. On 11/2/16, at 7:20 a.m. R56 was observed in the large dining room slouched part way down in high back tilt in space wheelchair. R56's body angled from left to right with legs dangled to right side off wheelchair. -At 7:30 a.m. the director of nursing services (DNS) walked through the dining room adjusted R56's glasses, spoke briefly to resident and left never offered to adjust resident position.	GOLDEN	N LIVINGCENTER - HO	A DRING		SOUTH		
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approached resident at the dining table offered a clothing protector however, never offered to adjust resident position even though the legs were still dangling. -At 7:44 a.m. to 8:06 a.m. resident remained in		large dining room s back tilt in space w from left to right wit wheelchair. -At 7:30 a.m. the di (DNS) walked throu R56's glasses, spo never offered to ad -At 7:32 a.m. nursir approached resider clothing protector h adjust resident pos were still dangling.	slouched part way down in high heelchair. R56's body angled th legs dangled to right side off irector of nursing services ugh the dining room adjusted ke briefly to resident and left just resident position. ng assistant (NA)-A nt at the dining table offered a nowever, never offered to ition even though the legs				

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If continuation sheet 14 of 54

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	00872 B. WING				11/	03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO)PKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	-At 8:20 a.m. R56 w right feet dangling of and a plate of food table. -At 8:29 a.m. NA-A resident pulled resi cued resident then resident up in the w arm and knee on e observation, the wh footrest was not ex dangling. -At 8:55 a.m. NA-A Broda wheelchair to the footrest down, p wheeled resident o reclining. -At 9:38 a.m. reside end of the hall acro reclined at 45 degro right and registered resident never offer -At 9:43 a.m. the ac resident never offer -At 9:43 a.m. licens approached R56 ar bed. LPN-C stated however left the fee hips were observed -At 9:51 a.m. LPN- NA-D wheeled resident on 11/3/16, at 9:17 seated on the Brod watching television tilted at approximate bottom was slumped	sed practical nurse (LPN)-C nd offered resident to go to she was going to adjust feet et still dangling and resident d off center to the right. -C returned with NA-A and dent into the room. T a.m. R56 was observed a wheelchair in the room . The wheelchair was slightly rely 30 degrees, and resident ed down on the wheelchair dge, legs hanging to the right				

Innesota Department of F TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
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2 830 Continued From p	age 15	2 830			
acknowledged res wheelchair and in needed to lay resi resident always di the nurses knew a had tried three dif however still was On 11/3/16, at 9:3 therapist (OT)-A r indicated the last OT-A was in 8/10/ OT-A verified ther the medical record assessment for pu On 11/3/16, at 3:4 rehabilitation state occupational thera the same wheelch was to reposition resident down if re rehabilitation indic to identify a change significant change for orders to treat rehabilitation furth locate the quarter this year however medical records. On 11/3/16, at 4:1 been seen for a b positioning. LPN-0 his feet on the sid	4 a.m. the occupational eviewed the medical record and time resident had been seen by 16, for a broken wheelchair. e was no notes or order were in d for the need to do a full				

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	725 SEC	OND AVENUE	SOUTH			
LIVINGCENTER - N	HOPKINS HOPKIN	S, MN 55343				
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Continued From pa	age 16	2 830				
positioning.						
rehabilitation verifie occupational therap for wheelchair posi forward she would done consistently to	ed there was no quarterly by screens completed for R56 tioning. She indicated moving ensure quarterly screens were o make sure the residents					
was in the dining ro R52 was slouched with knees above the hips were at approxi- knees higher than a pedals. -7:30 a.m. the DNS room and spoke wi adjust R52's wheel -7:32 a.m. NA-A off NA-A did not adjust -7:44 a.m. registered Care hospice took -7:55 a.m. RN-K re table and gave R52 were higher than the -8:14 a.m. R52 put room table. -8:21 a.m. RN-K c adjust his feet. -8:24 a.m. Breakfa NA-A adjusted R52 not above the table	bom reading the newspaper. part way down in Broda chair, he top of the table top. R52's ximately 45 degree angle with hips. R52's feet were on foot walked through the dining ith other residents and did not chair positioning. fered R52 a clothing protector. t R52's wheelchair positioning. ed nurse (RN)-K with Asera R52 out of the dining room. turned R52 to the dining room 2 a magazine. R52's knees he table top. shed self-back from dining hecked R52's foot rest and ast was placed in front of R52. 2's chair so R52's knees were a top.					
	PROVIDER OR SUPPLIER LIVINGCENTER - He SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From pa positioning. On 11/3/16, at 4:45 rehabilitation verifie occupational theray for wheelchair posi forward she would done consistently t were properly posit Souther, Glenora R52 was observed was in the dining ro R52 was slouched with knees above t hips were at approx knees higher than pedals. -7:30 a.m. the DNS room and Spoke we adjust R52's wheel -7:32 a.m. NA-A of NA-A did not adjus -7:44 a.m. register Care hospice took -7:55 a.m. RN-K re table and gave R52 were higher than tf -8:14 a.m. R52 pu room table. -8:21 a.m. RN-K c adjust his feet. -8:24 a.m. Breakfa NA-A adjusted R52 not above the table	OF CORRECTION IDENTIFICATION NUMBER: 00872 00872 PROVIDER OR SUPPLIER STREET A LIVINGCENTER - HOPKINS 725 SEC HOPKIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 positioning. On 11/3/16, at 4:45 p.m. the director of rehabilitation verified there was no quarterly occupational therapy screens completed for R56 for wheelchair positioning. She indicated moving forward she would ensure quarterly screens were done consistently to make sure the residents were properly positioning in the wheelchairs. Souther, Glenora R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table top. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals. -7:30 a.m. the DNS walked through the dining room and spoke with other residents and did not adjust R52's wheelchair positioning. -7:32 a.m. NA-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room. -7:54 a.m. R52 pushed self-back from dining room table. -8:21 a.m. RN-K checked R52's foot rest and	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00872 B. WING PROVIDER OR SUPPLER STREET ADDRESS, CITY, ST IVINGCENTER - HOPKINS 725 SECOND AVENUE HOPKINS, MN 55343 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 16 positioning. 2 830 On 11/3/16, at 4:45 p.m. the director of rehabilitation verified there was no quarterly occupational therapy screens completed for R56 for wheelchair positioning. She indicated moving forward she would ensure quarterly screens were done consistently to make sure the residents were properly positioning in the wheelchairs. 2 830 Souther, Glenora R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table top. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals. -7:30 a.m. the DNS walked through the dining room and spoke with other residents and did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees were higher than the table top. -8:14 a.m. RD-K checked R52's foot rest and adjust his feet. -8:24 a.m. Breakfast was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00872 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID REQUILTORY OR LSC IDENTIFYING INFORMATION) D PROVIDER FOR DEPICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREPIX Continued From page 16 2 830 000 11/3/16, at 4:45 p.m. the director of rehabilitation verified there was no quarterly occupational therapy screens completed for R56 for wheelchair positioning. She indicated moving forward she would ensure quarterly screens were done consistently to make sure the residents were properly positioning in the wheelchairs. Souther, Glenora R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was observed on 11/2/16, with Asera Care higher than hips. R52's feet were on foot pedals. -7:30 a.m. the DNS walked through the dining room and spoke with other residents and did not adjust R52's wheelchair positioning. -7:32 a.m. NA-A offered R52 a clothing protector. NA-A differed R52 out of the dining room table and gave R52's magazine. R52's knees were higher than the table top. -8:14 a.m. R1-K checked R52's foot rest and adjust his feet. -8:14 a.m. Brexkrast was placed	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00872 B. WING 11/1/1 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/1/1 IVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 10 BELIAH DEFICIENCY MUST BE PRECIDED BY FULL REQULATORY ON LSC DIENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACIDS (EACH OBRICING MUST BE PRECIDED BY FULL REQULATORY ON LSC DIENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH OBRICING SACULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 16 positioning. 2 830 CONTINUES TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) Continued From page 16 positioning. 2 830 Souther, Glenora 2 830 Souther, Glenora Souther, Glenora 2 830 Souther, Glenora R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was observed on 11/2/16, at 7:20 a.m. and digust R52's wheelchair positioning. Souther residents were properly positioning root cacing the newspaper. R52 was observed on 11/2/16, at 7:20 a.m. and these adproximately 45 degree angle with knees higher than higs. R52's feet were on foot pedals. Souther, RN-A offered R52 a tothing protector. -7:30 a.m. Nh-A offered R52 a tothing protector. -7:32 a.m. RN-K returned R52 to the dining room. -7:55 a.m. RN-K returned R52 to the dining room. -7:55 a.m. RN-K returned R52 to the dining r	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	C			
		00872	B. WING			11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	without telling R52 R52's eyes went wi mouth wide and up wheeled R52 to the -9:54 a.m. R52 was playing cards by his way down in chair. upright position. -10:52 a.m. R52 sit the position was un slouched down in th -10:55 a.m. activitie the parachute grou strap of the parach -11:16 a.m. LPN-C frequently R52 was repositioned out of "[R52] gets checke hours I will have to when he was last c -11:27 a.m. NA-A b room to locate a lift -11:30 a.m. NA-A re wait for a lift as the	eft the table top. ned Broda chair part way she was going to recline him. de open and R52 opened his per body stiffened. RN-D e main dining room. s sitting in Broda chair at table s self. R52 was sliding part The Broda chair was in an ting in chair playing cards and ichanged as R52 was ne chair. es assistant-A moved R52 to p and had R52 hold on to ute. was interviewed as to how to be toileted and the Broda chair. LPN-C said, d and changed every two ask the nursing assistants hanged." rought R52 to room and left and sling. eturned and said needed to					
	because R52 was a -11:39 a.m. NA-A a put gloves on. NA-A were doing. NA-A a and lifted R52 to a R52 into the bathro pants and removed	nd NA-B left to get EZ stand an EZ stand transfer. nd NA-B washed hands and A explained to R54 what they and NA-B put on EZ stand belt standing position and took om. NA-B pulled down R52's I the soiled incontinent brief. pad was very wet. NA-A and					

Minnesota Department of Health STATE FORM

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - HO	725 SEC	OND AVENUE	SOUTH		
GOLDER	LIVINGCENTER - R	HOPKINS HOPKINS	6, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 18	2 830			
	he was standing in red bloody area not NA-A and NA-B to p RN-D to assess an At 11:57 a.m. RN-D R52's scrotum and (cm.) long by x 0.5 was too shallow to said that was a new to call it a stage two (partial-thickness lo dermis. The wound moist, and may also ruptured serum-fille visible and deeper Granulation tissue,	c checked R52's bottom when the EZ Stand. There was a ted on scrotum. LPN-C asked out R52 in bed and then go get d measure the wound. 0 measured the wound on stated it was 1.5 centimeters cm. wide. RN-D said the depth measure. RN-D and LPN-C v wound and they were going o pressure ulcer oss of skin with exposed bed is viable, pink or red, o present as an intact or ed blister. Adipose (fat) is not tissues are not visible. slough and eschar are not long sitting and R52 sliding in				
	9/6/16, indicated R term memory probl dementia, osteoarth movement on one s thrive. R52's MDS i assistance with dre bed mobility and wa and bladder. R52's	ange of condition MDS dated 52 had both short and long ems and diagnoses of nritis, hemiplegia (loss of side of the body) and failure to ndicated R52 required ssing toileting, transfers and as always incontinent of bowel MDS identified R52 was at own and skin was intact.				
1innesota D	indicated R52 was and was at risk for down. The pressure indicated R52 was break down and pre Assessment for the	tinence CAA dated 4/15/16, dependent on staff for toileting moisture related skin break e ulcer CAA dated 4/15/16, at risk for worsening skin essure ulcers. The Care Area e most recent comprehensive were requested but not				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			C
		00872	B. WING			03/2016
AME OF F	PROVIDER OR SUPPLIER	STREI	ET ADDRESS, CITY, S	TATE, ZIP CODE		
	LIVINGCENTER - HO	OPKINS		SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	KINS, MN 55343	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 19	2 830		·	
	Swallow study care staff to ensure prop self-care deficit car 9/21/16, to toilet R5 survey process, the related to impaired bladder incontinent	Difficulty as related to Abno e plan dated 10/6/15, instruc- per positioning at meals. Re- re plan instructed staff on 52 every two hours. During e alteration in skin integrity physical mobility, bowel an ce, and the presence of scr for scrotum shearing care p	cted 52's the otal			
	11/1/16 through 11/	ninistration Record dated /30/16, indicated R52 was t ery two hours and as neede ler was 4/9/15.				
	Summary dated 7/2 caregiver education	Progress & Discharge 29/15, indicated, "Provided n on recommendations for ght alignment, Repositionin				
	unable to initiate se impairment and rec	-2 hours due to pt [patient] econdary to cognitive commendation for leisure at of pt on tables to reduce				
	said, "[NA-B] is at loone right now since	n 11/02/16 at 11:23 a.m. LP unch. I am going to have it ce I assume it should have hould have done it after				
	"I have not noticed	/2/16, at 11:48 a.m. NA-B s him sliding down in the cha m since before breakfast h two hours.	air. I			
	During interview 11	/2/16, at 2:03 p.m. LPN-C				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
	00872				11/	03/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 20	2 830			
	assistant director o wound is caused by pressure ulcer. The cream, off loading/r ordered a low air lo shearing was cause with the EZ stand." considered the slidi high knees as poss have requested hos therapist evaluate h During interview on said, "[R52] tries to in pain or is wet. If	11/3/16, at 10:04 a.m. NA-A move sometimes when he is he was at the table with his ble we should have sat him up	-			
	at 11:39 a.m. DNS NA-B had admitted when he should hav was not deliberate Office of Health Fav suspended NA-B u investigation, becau neglect under the v said, "I went and re educator and LPN- after lunch. The RN determined it looke traumatic injury. R5 and his scrotum is The ADNS said, "H and then standing v	th DNS and ADNS on 11/3/16, said they met with NA-B and he had missed checking R52 ve. The DNS said, "He felt it but I did report it to OHFC (the cility Complaints) and ntil we complete the use it could be construed as ulnerable adult act. The ADNS assessed with our RN clinical C. We reassessed R52 right I clinical educator and I d more like a shearing i2 is in a reclining wheel chair quite edematous and large." e slid down during the transfer with the standing lift. Because ood we feel it occurred during	· · · · · · · · · · · · · · · · · · ·			
	the transfer." The D	DNS also confirmed the ADNS ed nor is the RN clinical				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00872	B. WING		C 11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 21	2 830			
	ensure residents w and would not be s their wheelchairs. T expected staff to en upright while eating During interview or said, "R52 sits forw he is trying to pull h During interview or occupational therap usually provided th stated therapy had positioning. "We re repositioning of hip	n 11/3/16, at 1:29 p.m. LPN-D vard a lot. He almost looks like				
	was severely cogni understood others, for transfers, bed n personal hygiene a required supervisio indicated R21's dia chronic kidney dise chronic obstructive experienced cough was on hospice. Pressure Ulcer CA	PS dated 8/1/16, indicated R21 itively impaired, sometimes and was dependent on staff nobility, dressing, toileting, and wheel chair mobility. R21 on when eating. R21's MDS gnoses were dementia, ease, depression, anxiety, pulmonary disease and hing/choking during meals. R2 ⁻¹ A dated 2/25/16, indicated R2 ⁻¹	1			
	mobility needed a s wheelchair to reduc	e with transfers and wheelchai special seat cushion in ce or relieve pressure ual or at risk care plan printed	r			
	11/3/16, instructed	staff to provide pressure ir cushion and turning and				

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00872	D. WING		11/	03/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 22	2 830			
	impaired physical n staff "Wheelchair u hospice, staff to pro- unsafe food related recommended diet liquids care plan die mechanical soft ho evidenced by cough needing staff super therapy recommen- to follow with each speech therapy not plan did not address meals. On 11/2/16, at 7:20 room sitting in a low chair was partially r degrees from uprig chair, R21's feet we ground. The table t R21 was wearing b -7:30 a.m. the DNS room. -8:20 a.m. staff pla eggs, waffles, and c chair position uncha -8:32 a.m. R21 wa and choking. NA-A table and stayed wi clear his throat. LP before putting anoti chair remained rect at mid chest level. -8:51 a.m. R21 had	pureed pudding thicken et waiver signed allowing ney thickened liquids as hing with meals , resident vision with meals and speech dations for staff and resident meal. Recommendations from on the care plan. The Care s wheel chair positioning for a.m. R21 was in the dining v Broda chair. The back of reclined back about 15 ht. There were no foot rests or ere dangling just above the op was at R21's nipple line. lue anti slip socks. S walked through the dining aced breakfast of scrambled oatmeal in front of R21. Whee				
		led R21 out of the dining room bove the ground about an				

Minnesota Department of Health STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					С	
		00872	B. WING			03/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	Summary dated 1/2 [inch] wide x 16" de high right arm rest, cushion with slight for pt [patient] to ha and solid heel cont and to reduce risk Facilitated and pro- wheelchair mobility seat wheelchair. As feedback during m wheelchair. Facilita cueing during activ heel contact neede with wheelchair mo wheelchair position wheelchair position During interview or DNS stated she ex residents would be not be sliding repea chairs. DNS stated proper body alignm the residents were During interview or said R21 coughed signed a diet wavie was aware of the c notice [R21's] chair yesterday. Today h his chair upright. [F	Progress & Discharge 2/14, indicated, "Issued 18" eep,14" seat to floor height, 13' 16" seat back, Ischial step saddle-wheelchair has allowed ave increased stability at hips act needed for self-propelling for falls from wheelchair. vided graded assistance for r from appropriate 14" floor to ssessed and provided eals with 14" floor to seat ated and provided graded ities and exercises to increase ed for increased independence obility." Requested most curren ing assessment, no other ning assessments provided. n 11/3/16, at 11:39 a.m. the pected staff to ensure positioned properly and would atedly or leaning in their wheel expected staff to ensure nent in the wheelchair and that sitting upright while eating. n 11/3/16, at 1:38 p.m. LPN-D all the time. His family had er for quality of life. Hospice ioughing. LPN-D said, "I did no r was reclined at breakfast is chair was reclined so I lifted R21] should be sitting upright able should be lowered to the	t t			

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		00872	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO		OND AVENUE S, MN 55343	SOUTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 24	2 830			
	was in a 16 inch wi was 14 inch from th chair was 16 inches self-propelling the residents were not than the residents f	on 1/2/14, for positioning. R21 de wheel chair and the seat he floor (a standard wheel s). At that time R21 was wheelchair. OT-B stated if self-propelling a wheel chair feet should be supported. "We chair assessment for the Broda				
	R100 was severely understood others vision. R100's MDS dependent on staff and was incontinen MDS indicated R10 diagnoses of deme depression. Progre	DS dated 9/15/16, indicated cognitively impaired, rarely and had severely impaired 5 indicated R100 was for all activities of daily living, it of bowel and bladder. R100's 00 was on hospice and had ntia, hypertension anxiety and ss note dated 10/26/16, a stage two pressure ulcer.				
	R100 was totally de using a mechanica	A dated 12/31/15, indicated ependent on staff for transfers I lift, and needed a special sea air to reduce or relieve				
	11/3/16, instructed reducing wheelcha	tegrity care plan printed staff to provide pressure ir cushion and turn and g to schedule and as needed.				
	R100 into the main slouched down in E incontinence produ and R100's abdom	0 a.m. unidentified NA brough dining room. R100 was sitting Broda chair. R 100's ct was sticking out of the pant en was exposed. R100's legs d to the left and right. R100's	I			

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If continuation sheet 25 of 54

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
	I LIVINGCENTER - HO	725 SEC	OND AVENUE			
		HOPKIN	S, MN 55343			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 25	2 830			
	and stopped and sp -7:40 a.m. LPN-C a incontinence produ -8:07 a.m. R100 in crying. R100's shou and knees falling or -8:09 a.m. NA-D sp clothing protector. -8:22 a.m. LPN-D s adjusting R100's po -9:01 a.m. LPN-D v room. -9:06 a.m. NA-A bro	walked through dining room boke to R100. adjusted R100's shirt so the ct not seen. same position with intermitten ulders still angled to the left utwards with feet on foot rest boke with R100 and applied a sat down to feed R100 without				
	dated 11/21/14, ind demonstrated with wheelchair during r week has been sign personalized/custor wheelchair back, 5 pressure relieving of and elevated right a calf pad and foot re falls and increase of Requested most cu	ress & Discharge Summary icated, "Significant progress safe sitting in customized neals. Functional progress this nificant due to issued mized 18" wide kyphotic degree dump slight saddle cushion with armrest bolsters armrest, lateral trunk supports, ests in order to decrease risk o comfort during meals." urrent wheelchair positioning her wheelchair positioning ded.				
	said R100 should h	11/2/16, at 9:13 a.m. NA-A ave been repositioned during she looked uncomfortable.				
	a.m. NA-A said, "W	erview on 11/3/16, at 10:04 /hen [R100] cries she will chair. [R100] is turned and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00872	B. WING			03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 26	2 830			
	repositioned every	two hours."				
	stated expected sta be positioned proper repeatedly or leaning stated expected sta	11/3/16, at 11:39 a.m. DNS aff to ensure residents would erly and would not be sliding ng in their wheel chairs. DNS aff to ensure proper body neelchair and that the residents while eating.	5			
	said R100 was con extend out. When t extension mode R1 back up. LPN-D sa bolster but it does r	11/3/16, at 1:26 p.m. LPN-D tracted as her legs do not he legs are placed in the 00 would contract them right id, "Usually we use the side not work well so sometimes we o her from falling to the left."				
	said hospice usuall Therapy saw R100 placed in an 18 incl wheelchair and had trunk supports and was unable to say wheelchair was rep	11/3/16, at 4:29 p.m. OT-B y provides the Broda chairs. in November 2014. She was h kyphotic high back d a saddle cushion, lateral calf pads for her legs. OT-B when R100's customized blaced with a Broda chair. "We chair assessment for the Broda				
	provided Wheelcha 2/26/16. Procedure provide mobility for with safety and con staff that "Many typ available. Follow th for each type of wh instructed staff to "I on the foot rests if u	ning policy requested. Facility ir use of procedure dated indicated the purpose was to the non-ambulatory resident nfort. Procedure instructed es of wheelchairs are e manufacturer's instructions eelchair." The policy further Lower foot rest and place feet used. Position feet and legs in nt." The procedure did not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00872	B. WING			C 03/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	1	
	I LIVINGCENTER - HO	725 SEC	OND AVENUE			
		HOPKINS	6, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 27	2 830			
		y alignment or assessment for size of wheelchair.				
	instructs facility sta exclusively for resid institutions who are caregivers. The sui be determined by a familiar with the se- resident. Any other from possible liabili "2.6 Improper Use As outlined, the imp dangerous to the re parties, and can co the following: 1) Unauthorized op 2) Unauthorized mo 3) Inappropriate us who has not been a caregiver responsit	erating Manual dated 11/5/2009 ff "BRODA chairs are intended dents of long-term care a under the care of professiona itability of a BRODA chair must a qualified caregiver who is ating needs of the intended use of the chair is excluded ity claims." proper use of the chair is esident, caregivers, or third onsist of, but is not limited to peration of the chair's functions ovement of the chair. e of the chair for a resident assessed by a qualified ole for their seating. ently reposition the resident in				
	The repositioning p provided.	olicy was requested but not				
	Director of Nursing polices and proced monitoring non-pre and repostioning. designee could edu procedures. The D designee could dev	THOD OF CORRECTION: The or her designee could develop ures regarding assessing and ssure related skin conditions The Director of Nursing or her ucate staff on the policies and Director of Nursing or her velop a monitoring system to ceive the appropriate care.				
	TIME FRAME FOF (21) Days. epartment of Health	CORRECTION: Twenty One				

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING	·		С
	00872	B. WING			03/2016
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LIVINGCENTER - HO	DPKINS				
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
		PREFIX TAG			COMPLET DATE
MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			12/13/1
comprehensive res home must ensure	ident assessment, a nursing that:				
treatments and ser abilities in activities	vices to maintain or improve of daily living unless				
the resident's cond part, activities of da	ition. For purposes of this ally living includes the				
(1) bathe, dres (2) transfer an	ss, and groom; id ambulate;				
This MN Requirem	ent is not met as evidenced				
by: Based on observat review, the facility f toilet who was depe 1 of 4 (R52) resider	ion, interview and document ailed to assist a resident to the endent on staff for toileting for nts observed during		Corrected		
Findings include:					
7:20 a.m. until 11:5 On 11/2/16, at 7:20 room reading the n part way down in B	7a.m. and the following noted: a.m. R52 was in the dining ewspaper. R52 was slouched roda chair, with knees above				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L MN Rule 4658.052 Subp. 6. Activities comprehensive resis home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speec functional commun This MN Requirem by: Based on observat review, the facility f toilet who was depe 1 of 4 (R52) reside observation for whe Findings include: R52 was continuou 7:20 a.m. until 11:5 On 11/2/16, at 7:20 room reading the n part way down in B	OF CORRECTION IDENTIFICATION NUMBER: 00872 00872 PROVIDER OR SUPPLIER STREET AL 725 SECC HOPKINS 725 SECC HOPKINS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist a resident to the toilet who was dependent on staff for toileting for 1 of 4 (R52) residents observed during observation for wheelchair positioning. Findings include:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00872 B. WING	OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: 00872 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, NM 55333 PROVIDER'S PLAN OF CORI SUMMARY STATEMENT OF DEFICIENCY (EACH ORRECTIVE MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDER'S PLAN OF CORI MN Rule 4658.0525 Subp. 6 A Rehab - ADLs 2 915 CROSS-REFERENCED TO THE OCOMPRENIVE resident assessment, a nursing home must ensure that: 2 915 A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and Corrected This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist a resident to the toilet who was dependent on staff for tolleting for 1 of 4 (R52) residents observed during observation for wheelchair positioning. Corrected Findings include: R52 was continuous observation on 11/2/16, from 7:20 a.m. until 11:57.am. and the following noted: On 11/2/16, at 7:20 a.m. R52 was in the dining room reading the newspaper. R52 was souched part way down in Broda chair, with knees above Corrected <td>OF CORRECTION IDENTIFICATION NUMBER: A BUILDING:</td>	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING:

Minnesota Department of STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	00872	B. WING		11/	03/2016
NAME OF PROVIDER OR SUPPLIE	R STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN LIVINGCENTER -	HOPKINS	COND AVENUE IS, MN 55343	SOUTH		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915 Continued From	page 29	2 915		,	
-7:44 a.m. registe Care hospice too -7:55 a.m. RN-K table and gave R -8:24 a.m. Break had not left the d -9:03 a.m. license wheeled R52 to t positioned him at - 9:50a.m. RN-D dining room for a -10:52 a.m. R52 Position unchang the chair. R52 re had not left the a -10:55 a.m. activ the parachute gro strap of the parae -11:16 a.m. LPN- frequently R52 w repositioned out "[R52] gets check hours I will have when he was las -11:27 a.m. NA-A room to locate a -11:30 a.m. NA-A wait for a lift as th -11:36 a.m. NA-A mechanical lift. -11:38 a.m. NA-A because R52 wa -11:39 a.m. NA-A	ered nurse (RN)-K with Asera k R52 out of the dining room. returned R52 to the dining room 52 a magazine. fast placed in front of R52. R52 ining room since 7:44 a.m. ed practical nurse (LPN)-D he small dining room and a table. wheeled R52 back to the main n activity. sitting in chair playing cards. ed with R52 slouched down in mained in the dining room and rea. ties assistant-A moved R52 to bup and had R52 hold on to chute. C was interviewed as to how as to be toileted and of the Broda chair. LPN-C said, ked and changed every two to ask the nursing assistants changed." brought R52 to room and left lift and sling. returned and said needed to hey only had one lift. C entered room and obtained serve cares. and NA-B left to get EZ stand s an EZ stand transfer. and NA-B washed hands and A-A explained to R54 what they				

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If continuation sheet 30 of 54

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00872	B. WING		C 11/03/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 30	2 915				
	and NA-B lowered	ed the pad was very wet. NA-A R52 to the toilet seat and s. Staff exited the bathroom to					
	Data Set (MDS) da both short and long diagnoses of deme (loss of movement failure to thrive. R5 required assistance transfers and bed r incontinent of bowe	hange of condition Minimum ated 9/6/16, indicated R52 had g term memory problems and entia, osteoarthritis, hemiplegia on one side of the body) and 52's MDS indicated R52 e with dressing toileting, mobility and was always el and bladder. R52's MDS at risk for skin breakdown and					
	Assessment (CAA) was dependent on risk for moisture re Pressure ulcer CA was at risk for wors pressure ulcers. C	ntinence Care Area) dated 4/15/16, indicated R52 staff for toileting and was at lated skin break down. A dated 4/15/16, indicated R52 sening skin break down and care Area Assessment for most 9/6/16, were requested but not	:				
	on 9/21/16 to toilet During survey proc integrity related to bowel and bladder	icit care plan instructed staff R52 every two hours tess R52 's alteration in skin impaired physical mobility, incontinence presence of at risk for scrotum shearing atted.					
	said, "[NA-B] is at I done right now sind	n 11/2/16, at 11:23 a.m. LPN-C unch. I am going to have it ce I assume it should have ing toileting of R52]. They it after breakfast."					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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	0. 00		A. BUILDING: _				
		00872	B. WING			C 11/03/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
RÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 915	Continued From pa	age 31	2 915				
		/2/16, at 11:48 a.m. NA-B said him since before breakfast he ery two hours. "					
	at 11:39 am DNS s	th DNS and ADNS on 11/03/16 aid they met with NA-B and nad missed checking R52 ve.	;				
	Toileting policies re	quested but not provided.					
	The DON or design as necessary the p regarding the need services. The DON training for all appr and procedures an documentation. Th	e DON or designee (s) could all residents are receiving					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			12/13/1	
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,					
	This MN Requirem	ent is not met as evidenced					

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING			C 11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENU 6, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 920	Continued From pa	age 32	2 920				
	review, the facility f 1of 1 resident (R28	ion, interview and document failed to provide assistance for b) reviewed for activities of daily assistance with shaving.	,	Corrected			
	Findings include:						
	p.m. R28 was obse on right edge of mo	servation on 10/31/16, at 1:42 erved to have black facial hair buth. On 11/1/16, at 12:23 p.m. mains on R28 right side of					
	changed R28's inco R28 to get dressed R28's hair. NA-C to dining room for bre	a.m. Nursing assistant (NA)-C ontinence product assisted and wash face. NA-C combec ook R28 to a table in small eakfast. R28 had eight black on the right side of mouth.					
	and performed inco was done R28 still	a.m. NA-C took R28 to room ontinence cares. When NA-C had approximately eight black he right side of mouth.					
		daily living Care Area 4/6/16, indicated R28 required poming.					
	R28 was severely of diagnosis of demending pain. R28's MDS in	OS dated 9/14/16, indicated cognitively impaired with ntia, depression, and chronic ndicated R28 required rsonal hygiene including					
		ctioning deficit care plan tructed staff to assist R28 with					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COM	E SURVEY PLETED C
		00872	B. WING		11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS .	OND AVENU S, MN 55343			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 920	Continued From pa	ige 33	2 920			
	R28 was asked abo	11/3/16, at 7:21 a.m. when out facial hair, R28 replied, "A facial hair. Do I have facial				
	said, " She accepts not shave her today little mustache. I no two days depending	11/3/16, at 9:58 a.m. NA-C s and appreciates help. I did y. I was so busy. She has a prmally shave her after one to g on the beard. We are to look n she gets up and shave her it ave done so today."				
	The director of nurs ensure that residen activities of daily liv	THOD OF CORRECTION: sing and or designee could its who are unable to carry out ing receive the necessary n good nutrition, grooming, oral hygiene.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One)			
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			12/13/16
	procedures and co	conditions. Sanitary nditions must be maintained ir dietary department at all	1			
	by: Based on observati review, the facility f stored and prepare	ent is not met as evidenced ion, interview and document ailed to ensure food was d under sanitary conditions paration equipment was not		Corrected		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:			с	
		00872	B. WING			11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21015	Continued From pa	age 34	21015				
	temperatures were ensure safe food s and an ice machine maintained in a sar potential to affect 1	d repair, refrigerator e not appropriately monitored to torage in 2 of 6 kitchenettes, e in 1 of 6 kitchenettes was not nitary manner. This had the 03 of 106 residents in the ed their meals from the kitchen					
	Findings include:						
	tour, a Hobart large the counter of the b by the wall. The sta observed attached clear plastic splash of the mixing bowl. attached to the bow and broken and ap assistant dietary m verified the plastic was still being used asked how long the	02 a.m. during the initial kitcher e mixing bowl was observed or back kitchen preparation area ainless steel mixing bowl was to the machine and a hard n guard was in place on the rim The plastic splash guard wl was observed to be cracked peared brittle to touch. The anager was interviewed and splash guard was broken but d for food preparation. When e splash guard had been like dieteary manager stated, ot been looking."	1				
	was completed with and the DM was as splash guard on the	14 p.m. a follow up kitchen tour h the dietary manager (DM) sked about the broken plastic e mixing bowl. The DM stated rted and a new splash guard ed.					
	the executive direc had not been awar however, when it w	19 p.m. during interview with tor (ED), the ED stated she e the splash guard was broker vas brought to her attention M to remove it from the kitcher aced.					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET #	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	COND AVENUI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE
21015	Continued From pa	age 35	21015			
	Equipment directed	ed policy Maintaining Dietary d: "The dietary equipment ed for the health and safety or associates"	f			
	Souther, Glenora					
	The Administrator a and revise food ser to assure that food manner. Staff coul The Certified Dieta	THOD FOR CORRECTION: and the Dietician could review rvice policies and procedures is served in a sanitary d be trained as necessary. ry Manager could monitor the rage and preparation on a				
	TIME PERIOD FOI One (21) days.	R CORRECTION: Twenty-				
21025	MN Rule 4658.061	5 Food Temperatures	21025			12/13/16
	40 degrees Fahren or below, or 150 de centigrade) or abou food" means any fo and temperature co	us food must be maintained a heit (four degrees centigrade) grees Fahrenheit (66 degrees ve. "Potentially hazardous bod subject to continuous time ontrols in order to prevent the ive growth of infectious or anisms.	5			
	by: Based on observat review, the facility f refrigerator temper	ent is not met as evidenced ion, interview and document ailed to ensure acceptable atures were maintained to orage of beverages in 2 of 6		Corrected		

Minnesota Department of Health STATE FORM

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If continuation sheet 36 of 54

ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00872	B. WING			C 11/03/2016	
IAME OF PROVIDER OR SUPPLIER STREET			TATE, ZIP CODE			
LIVINGCENTER - HO			SOUTH			
(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				(X5) COMPLET DATE	
Continued From pa	age 36	21025				
out of 106 residents	s who utilized beverages from					
Findings include:						
Kitchenettes						
2 North Main dining	g room					
North main dining r seal was observed hanging loose belo The thermometer in	oom refrigerator door bottom to be stained black and w the door. ndicated the temperature was					
8:03 a.m. the dietic the refrigerator was were four cartons of thickened juice and	ian verified the temperature in 51 degrees and that there of milk and seven boxes of I two boxes of thickened milk					
(NA)-B verified givi and milk from the r giving R21 nectar t	ng R30 nectar thick apple juice efrigerator. NA-B verified hick water and milk, and R56	9				
verified refrigerator 59 degrees Fahren -7:48 a.m. no one h	temp 15 degrees Celsius or heit. had entered refrigerator since					
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER LIVINGCENTER - HO SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From park kitchenettes. This h out of 106 residents these refrigerators. Findings include: Kitchenettes 2 North Main dining During a tour on 10 North main dining r seal was observed hanging loose belo The thermometer in 50 degrees Fahren During a tour with t 8:03 a.m. the dietic the refrigerator was were four cartons of thickened juice and also stored in the re giving R21 nectar t and R52 honey thic the refrigerator. 11/02/16, continuou until 8:15 a.m. inclu -7:18 a.m. licensed verified refrigerator 59 degrees Fahren -7:48 a.m. no one h	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00872 PROVIDER OR SUPPLIER STREET A 725 SEC HOPKINS PROVIDER OR SUPPLIER STREET A 725 SEC HOPKIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 kitchenettes. This had the potential to affecct 26 out of 106 residents who utilized beverages from these refrigerators. Findings include: Kitchenettes 2 North Main dining room During a tour on 10/31/16, at 7:28 a.m. the 2 North main dining room refrigerator door bottom seal was observed to be stained black and hanging loose below the door. The thermometer indicated the temperature was 50 degrees Fahrenheit. During a tour with the dietician on 10/31/16, at 8:03 a.m. the dietician verified the temperature in the refrigerator was 51 degrees and that there were four cartons of milk and seven boxes of thickened juice and two boxes of thickened milk also stored in the refrigerator. On 10/31/16, at 8:28 a.m. nursing assistant (NA)-B verified giving R30 nectar thick apple juice and milk from the refrigerator. NA-B verified giving R21 nectar thick water and milk, and R56 and R52 honey thick apple juice and milk from	TO F DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING:	TO P DEFICIENCIES (X1) PROVIDERISUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION OP CORRECTION 00872 B. WING	TO F DEFICIENCIES (M) PROVIDERSUPPLIERCLAND ARX MULTIPLE CONSTRUCTION (XXX MULTIPLE CONSTRUCTION 11/// PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZP CODE III 11// SUMMARY STATEMENT OF DEFICIENCIES TZS SECOND AVENUE SOUTH PROVIDER'S PLAN OF CORRECTION IELEVINGECENTY WIST BE PRECEDED BY FULL III PROVIDER'S PLAN OF CORRECTION REGULATORY OF USC DENTIFYING INFORMATION III PROVIDER'S PLAN OF CORRECTION Continued From page 36 21025 kitchenettes IIII PROVIDER'S PLAN OF CORRECTION Continued From page 36 21025 kitchenettes IIIIII PROVIDER'S PLAN OF CORRECTION Continued From page 36 21025 kitchenettes IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
						С
		00872	B. WING		11/0	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS		SOUTH		
(X4) ID	SUMMARY ST		6, MN 55343	PROVIDER'S PLAN OF (COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
21025	Continued From pa	age 37	21025			
	there are several the three pitchers of juit containers of yogur -7:59 a.m. dietary a refrigerator door are temperature of the degrees when show 40 then asked to cl degrees. -8:03 a.m. cook-A of refrigerator temper degrees. Cook-A si everything and hav Cook-A removed a refrigerator	half gallon of chocolate milk. nickened fruit juices cartons, ice and several individual rt in the refrigerator. aide (DA)-A opened the nd closed it. When asked the fridge the DA-A said 40 wn the thermometer said it was heck again said it was 50 came up and checked the ature and said it was 55 tated, "I am going to remove re maintenance come right up." Il food items from the enance-A arrived to look at				
	was an open yogur been open 10/26/1 on 10/31/16, at 8:0	n 10/31/16, at 7:33 a.m. there t that was labeled as having 6. During tour with the dietician 8 a.m. the dietician verified late of open, the yogurt should				
	room refrigerator te be 50 degrees. In t container of potato pitchers of various	g room /31/16, the 1 West main dining emperature was observed to he refrigerator there was a salad dated 10/24/16, eight juices, one box of nectar thick ple and cranberry juice.				
nnosota D	a.m. the dietician v temperature was 6	e dietician on 10/31/16, at 7:57 erified the refrigerator 2 degrees. The dietician stated od born illness with the gh.				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BUILDING:		С	
		00872	B. WING			03/2016
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
OLDEN	LIVINGCENTER - HO	DPKINS	COND AVENUE IS, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21025	Continued From pa	age 38	21025			
	2 East Main dining	2 East Main dining room				
	spout was soiled, b potentially unsafe. During observation machine spout was no sign on the mac should not be used During a follow up t with the dietician ar machine spout was black. A sign indica used. During the o Manager wiped sor the spout and state bicarb and build up The dietician stated when I noticed it ha notified maintenance it."	tour on 11/03/16 at 12:41 p.m. and dietary manager, the ice is still observed to be soiled ated the machine should not b observation, the Dietary me of the black substance off ed, "It is a mixture of lime, of other unknown substance. d, "I put the sign up yesterday ad still not been cleaned. I had be on Monday to take care of	e "			
	refrigerator tempera degrees and above not maintained in the food borne illness f foods like milk and because of risk for stated food should	4 a.m. the dietician stated the atures should be below 40 a freezing. If the temperature is hat range there is high risk of rom temperature sensitive potato salad or thickened juic bacterial growth. Dietician be dated when opened and r three days after being	S			
		28 a.m. NA-B said, "I did not ture before I removed the milk em to residents."				
	On 11/2/16, at 1:55					1

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION	COM	E SURVEY PLETED	
		00872	B. WING			C 11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21025	Continued From pa	age 39	21025				
	increased it to the o	et on the warmest setting so I coolest and tightened the door < the coils and they were okay.					
	executive director s temperatures to be regulation. ED state responsible for more notify the dining se they are too warm it comes to me and issues are corrected informed on Monda with refrigerator ter issues to continue.	n 11/03/16 at 12:24 p.m. the said she expected refrigerator within normal guidelines per ed she expect staff were nitoring the temperatures to rvice director or maintenance i "Once those reports are made I then we talk about how those ed." ED further stated "I was ay that there were some issues mps. I would not expect the If there is an issue I would xed timely so we can continue	f,				
	dietician said she n about the warm ref removed the food o	n 11/3/16, at 12:41 p.m. the notified maintenance Monday rigerator temperatures and on Monday and again on e refrigerator on 2 North.					
	dated 2011, directe Department to stor degrees F [Fahren] manner as to preve	ge of Refrigerated Foods policy ed the Dining Services e refrigerated food at 41 heit] or below and in such ent spoilage and contamination plicy guidelines and federal ulations.					
	RD or designee co procedures to ensu- are held at the prop borne illness. The I all appropriate staff	THOD OF CORRECTION: The uld develop policies and ure potentially hazardous foods per temperature to avoid food RD or designee could educate f on these policies and D or designee could develop	;				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00872	B. WING			03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5) COMPLET
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	DATE
21025	Continued From pa	age 40	21025			
	monitoring systems compliance.	s to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			12/13/16
	maintain a compre- infection control pre- current tuberculosi- issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance				
	regarding impleme	ntation of the guidelines. ance with this subdivision musi	t			
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the sure symptom screens were 5 employees (RN-C and NA-E culosis (TB).)	Corrected		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	A. BUILDING:		С
		00872	B. WING	B. WING		03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21426	Continued From pa	ige 41	21426			
	Findings include:					
	was reviewed and i	RN)-C's employment record ncluded a hire date of 9/20/16. It record did not include a r TB.				
	Nursing assistant (I was reviewed and i	NA)-E's employment record ncluded a hire date of 9/13/16. t record did not include a				
	interviewed on 11/3 RN-C and NA-E dic completed upon hir on to say that they annually, and as RI	ces director (HRD) was /16 at 10:35 a.m. confirmed d not have symptom screens re at the facility. The HRD went complete symptom screens N-C and NA-E were new build not have had a symptom				
	services (DNS) con	5 p.m. the director of nursing firmed all new employees pleted TB symptom screen				
	the facility used the Control in Minnesot handbook dated Ju handbook indicated	sted and the HRD indicated "Regulations for Tuberculosis ta Health Care Settings" ly 2013. Review of the d all newly hired employees hentation of a TB symptom				
	The infection contro designee could revi procedures to ensu included. Appropria	THOD OF CORRECTION: of coordinator/nurse or iew the TB policies and ire required information is ate staff could be educated ents. Audits could be could be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :		E SURVEY PLETED
					С	
		00872	B. WING		11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	NDKINS	OND AVENU			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21426	Continued From pa	age 42	21426			
	conducted and the committee meeting	results reviewed at the quality JS.	,			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			12/13/16
	must store all drug under proper temp	e of drugs. A nursing home s in locked compartments erature controls, and permit rsing personnel to have				
	by: Based on observat review, the facility t and biologicals we properly in 3 of 3 m	ent is not met as evidenced ion, interview and document ailed to ensure medications re stored and disposed of nedication rooms, and one riewed for medication storage.		Corrected		
	Findings include:					
	of Tuberculin (a me Tuberculosis) read had an unreadable vials were open bu	ation room had four open vials edication to skin test for y and stored for use. One vial date when opened. Three t undated. It was unclear why vials of Tuberculin open at the				
	vial of tuberculin th	tion refrigerator had an expire at was open and dated /16 (the medication expired).	d			
	The 2 East medica	tion refrigerator had one vial o	f			

STATE FORM

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		725 SEC	OND AVENUE	SOUTH		
GOLDER	N LIVINGCENTER - HO	HOPKINS	6, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21610	Continued From pa	age 43	21610			
	tuberculin that was	open but undated.				
	Facility, Storage of I 3 or 3, date written Section E, "When t manufacturer's con the container or via 1) "The nurse s sticker on the medi opened and the [ne the best sticker to a opened" and "expir expiration date of th days unless the ma another date or reg differenent dating (WITH SHORTENE	he original seal of a Itainer or vial is initially broken, I will be dated. shall place a [Date Opened] cation and enter the date ew date of expiration] (NOTE: affix contain both a "Date ration" notation line). The he vial or container will be [30] anufacturer recommend julations/guidelines require see 11.21- MEDICATIONS D EXPIRATION DATES)."				
	(LPN)-B was obser to R33. R33 was ob medications, then s floor approximately then picked up the returned to the med (without performing matched the pill ret Vitamin D, and pou she picked up a wh paused and looked surveyor asked LPI medications into he then scooped up th	a.m. licensed practical nurse ved administering medication oserved to swallow some spit a white round pill onto the two feet in front of him. LPN-E pill with her hand (no glove), dication cart and opened it hand hygiene). LPN-B rieved from the floor with ired two more into her hand, hite plastic spoon, and then at surveyors. At this time one N-B if she usually did put er hand. LPN-B stated "no" the three round white pills with them into the trash receptacle	3			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00872	B. WING			03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	ige 44	21610			
	on the medication of	cart.				
	should not have pu they were going to also verified that m into the garbage, bu medication disposa medication room. H check with the direct before giving the fir would only dispose medication room di spit it onto the floor -At 2:37 p.m. RN-A "technically it shoul orange bin, in the n	stated the DNS verified, d be [disposed of] in the nedication room." RN-A one orange medication				
	Medications policy following equipeme acquired and maint proper storage, pre medications: 10) Disposal contai	d Supplies for Administering revised 2014, indicated the ent and supplies should be ained by the facility for the paration, and administration of iner for medications, sharps, waste generated during stration.				
	The director of nurs develop, review, an procedures to ensu vaccination solutior not expired. The dir designee could edu the policies and pro	THOD OF CORRECTION: sing (DON) or designee could id/or revise policies and ire medications including n, are appropriately stored and rector of nursing (DON) or ucate all appropriate staff on ocedures. The director of esignee could develop is to ensure ongoing				

If continuation sheet 45 of 54

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED	
		00872	B. WING			C 11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	A DRING	OND AVENU 5, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE	
21610	Continued From pa	age 45	21610				
	compliance.						
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-one					
21665	MN Rule 4658.140	0 Physical Environment	21665			12/13/16	
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.					
	by: Based on observat review, the facility f functional, sanitary which included 17 (201, 202, 203, 204 222, 243, 254, 259	ent is not met as evidenced ion, interview and document failed to ensure a safe, and comfortable environment rooms and on the second floor 4, 205, 207, 210, 211, 220, , 260, 261, 262, 277) and the within these rooms.		Corrected			
	Findings include:						
	p.m. with the execu maintenence direct employee (M-A), th (H-M) and executiv	tor (M-D), maintenance ne housekeeping manager re director interns (ED-A and g observations were identified					
	jagged edges and	athroom door frame had scrapes along the door, plaster exposed and the bathroom h urine.					
	-Room 202-The flo	or was sticky with urine, the					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			С
		00872			11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ COND AVENUE			
GOLDEN	I LIVINGCENTER - H	OPKINS	S, MN 55343	300111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 46	21665			
	porcelein in the toil	et was scratched.				
	-Room 203-A large back of the room d	gouge was observed on the oor.				
	-Room 204-The do the egdes.	oor had large scratches along				
	gouges and the lini	athroom door had deep ing on the back of the toilet he bathroom had a urine odor.				
	floor vinyl was com	athroom smelled of urine, the ning up and there was a used obstance on the sides of the back of the toilet.				
	of the bed room do The floor was stain	were gouges out of the back or and at the top of the door ied in the bathroom. A facility vas ripped and the cushion was	5			
	along the back of the	r was exposed coming up he wall and edge of the toilet e bathroom were scraped.				
	urine odor, the bath	om and bathroom had a strong nroom door had several nd there was black staining of the toilet.	3			
	bathroom door and on the toilet. The v	were large gouges in the I the porcelain had worn away vall was scraped, exposing I of the bed in the bedroom. of body odor.				
	-Room 243- The to the bathroom.	ilet cover did not fit the toilet ir	ı			

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - H	NDKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 47	21665			
		oleum was coming up in the firmed by the Administrator as				
		neelchair cushions were on was exposed on the n and foot rests.				
	-Room 262-The flo and there was a st	or was sticky in the bathroom rong urine odor.				
		athroom smelled of urine and on the bathroom wall				
	DON or designee of conduct periodic as frequent to ensure	THOD OF CORRECTION: The could educate staff and udits of areas residents a safe and home like ained to the extent possible.	•			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One	•			
21805	MN St. Statute 144 Residents of HC F	.651 Subd. 5 Patients & ac.Bill of Rights	21805			12/13/1
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by: Based on observat	ent is not met as evidenced ion, interview, and document failed to provide visual privacy		Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO		COND AVENUE NS, MN 55343	SOUTH		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21805	Continued From pa	ge 48	21805			
	for 1 of 3 residents incontinence	(R44) reviewed for urinary				
	Findings include:					
	a.m. the door of the the nursing station assistant (NA)-A re- licensed practical n able to see R44 sea abdomen, left hip a standing outside the blue shirt pulled up	oservation on 11/3/16, at 7:13 e shower/tub room across fror was noted open. Nursing quested something from urse (LPN)-D. Surveyor was ated on the toilet. R44's bare nd left thigh were visible when e hallway. R44 was wearing a and dark blue sweat pants s feet lying on the floor in fror	n ı			
	was brought to the the nurses' station. was no curtain arou room. At 9:51 a.m. shower room. Surve was able to see R4 a.m. NA-A then ent	on 11/3/16, at 9:45 a.m. R44 shower/tub room across from NA-A and NA-C verified there and the toilet in the shower/tub NA-A and NA-c exited the eyor sitting at the nursing des 4 sitting on the toilet. At 9:57 ered the shower room and to see R44 sitting on the toilet y exposed.	i e o k			
	10/12/16, indicated impaired with verba others one to three period. R44's MDS assistance of two s frequently incontine incontinent of bowe indicated resident of and seizure disorder	imum Data Set (MDS) dated R44 was severely cognitively I behaviors that affected days during the observationa indicated R44 required taff to use the toilet, and was ent of bladder and always I. In addition, R44's MDS liagnoses included dementia er. R44's care plan dated R44 was incontinent of bowel				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 49	21805		,	
	toilet.	•				
	stated "we normally room because it is bars and can do the stated, "There has the toilet just in fror careful when we op into the room." On 11/3/16, at 3:58	a 11/3/16, at 10:04 a.m. NA-A y bring [R44] to the shower safer. [R44] can use the grab e work himself." NA-A further never been a curtain around at of the shower. We try to be been the door but you can see a p.m. family member (FM)-B be upset if someone could see				
		n. If he were aware that e him, he would tell them to get loor."	t			
	director of nursing a needed to maintain further stated she w not a curtain in from	11/03/16, at 11:39 a.m. the services (DNS) stated staff privacy for all residents. DNS vas not aware that there was at of the toilet in the shower/tub mer's unit as there had been				
		ence Care policy reviewed aff to "Drape resident for				
	indicated "All reside and in an environm enhances each res full recognition of h residents with dign enhances each res improves his or her	policy reviewed 3/31/16, ents will be treated in a manner ent that maintains and ident's dignity and respect in is or her individuality. Treating ity and respect maintains and ident's self-worth and r psychosocial well-being and	r			
	maintain dignity by	cy further instructed staff to "Assisting residents in daily manner (e.g., pushing				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
			A. BUILDING:			
		00872	B. WING			C 03/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, S	STATE, ZIP CODE		
OLDEN	I LIVINGCENTER - HO	OPKINS		SOUTH		
(X4) ID	SUMMARY STA		IS, MN 55343	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET
21805	Continued From pa	age 50	21805			
		n wheelchairs, covering d to resident, ensuring xposed)."				
	DON or designee of and respect. The D interview residents	THOD OF CORRECTION: Th could educate staff on dignity ON or designee could then routinely to ensure residents d respect are being	e			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One	e			
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			12/13/1
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve the vsical and mental functioning. where the service is not iblic or private resources.				
	by: Based on observat review, the facility f within at reach for 2	ent is not met as evidenced ion, interview, and document ailed to ensure call lights were 2 of 4 residents (R74, R54) r falls during random	9	Corrected		
	Findings include:					
	R74's annual Minin	num Data Set (MDS) dated				

STATE FORM

KKYX11

If continuation sheet 51 of 54

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00872	B. WING			C 03/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	cognition and was a make his needs un indicated resident r activities of daily liv	R74 had severely impaired able to understand others and derstood. R74's MDS needed assistance with all ing and diagnoses included is), arthritis and Alzheimer's.				
	a.m. R74's call ligh	bservation on 10/31/16, at 7:22 t was observed down the back red nurse (RN)-D verified that ithin R74's reach.				
	10/18/16 indicated	a Assessment (CAA) dated R74 was aware of what was It had problems with memory				
	care plan dated 9/2 call bell within reac use call bell as nee initiated 9/22/16 ins	elimination bowel and bladder 2/12, instructed staff to ensure h and provide reminders to ded. Fall risk care plan structed staff to have call light wailable and in easy reach or	•			
	During interview on stated R74 seldom	10/31/16, at 7:22 a.m. RN-D used the call light.				
		i 10/31/16 at 7:26 a.m. nursing iid "oh yes [R74] can use his				
	R54 had moderated sometimes able to sometimes able to indicated R54 want communicate with	S dated 10/7/16, indicated ly impaired cognition and was understand others and be understood. R54's MDS ted an interpreter to health care staff. In addition R54's diagnoses included low				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED				
		00872	B. WING		00872 B. WING		00872 B. WING			C 03/2016
NAME OF I	PROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, S	TATE, ZIP CODE						
GOLDEN	I LIVINGCENTER - HO	OPKINS	SECOND AVENUE PKINS, MN 55343	SOUTH						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE				
21810	Continued From pa	age 52	21810							
		rillation, depression and d assistance with all activit	ies							
	was blind, had incre in activities of daily 1/22/15, indicated F	lated 1/25/16, indicated R eased risk for falls and de living. R54's care plan da R54 was at risk for falls ar ave call light or personal i sy reach.	cline ted id							
	service (DSS) and up an initial intervie line translator. DSS room but could not a portable phone. F lying on the floor ne in bed. DSS called handed the phone light up and give it to R54's room to se At 1:38 p.m. survey call light. NA-F veri NA-F did not check exiting the room. A interview with R54, without moving it. N and verified call ligh	p.m. the director of social surveyor entered R54 to so with R54 using the lang blooked for the phone in F find it. DSS went and obta R54's call light was observ ext to R54's bed. R54 was R54's family on the phone to R54. DSS did not pick of to R54. DSS had NA-F co be if R54 needed assistan- yor asked NA-F if R54 use fied R54 used the call light call light location prior to t 1:52 p.m. after completin surveyor put on the call ligh NA-G answered the call ligh t was on the floor and our gave the call light to R54.	et luage R54's ained ed lying and call me ce. d the t. g ght ht t of							
	indicated the purport to resident's call for system is in proper further instructs star residents be sure to conveniently for the resident where the	rocedure reviewed 10/11/ se was "to respond promp r assistance. To ensure ca working order. Procedure off "when providing care to position the call light e resident to use. Tell the call light was and show the call light. "Be sure all	otly III 9							

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAIN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·		
		00872	B. WING			C 03/2016
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	LIVINGCENTER - HO	725 SEC	OND AVENUE	SOUTH		
	ENINGCENTER - IN	HOPKINS	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21810	Continued From pa	age 53	21810			
	lights are placed or the floor or bedside	n the bed at all times, never on e stand.				
	The director of nurs develop, review, an procedures to ensu- resident reach. The designee could edu the policies and pro- nursing (DON) or d monitoring systems compliance.	THOD OF CORRECTION: sing (DON) or designee could nd/or revise policies and ure call lights are kept within a director of nursing (DON) or ucate all appropriate staff on ocedures. The director of lesignee could develop s to ensure ongoing R CORRECTION: Twenty-one				